THE CRACK COCAINE CRISIS

JOINT HEARING

BEFORE THE

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL HOUSE OF REPRESENTATIVES

AND THE

SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

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TUESDAY, JULY 15, 1986

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(99th Congress)

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THE CRACK COCAINE CRISIS

TUESDAY, JULY 15, 1986

HOUSE OF REPRESENTATIVES, SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL AND SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES,
Washington, DC.

The committees met, pursuant to call, at 9:40 a.m., in room 2141, Rayburn House Office Building, Hon. Charles Rangel (chairman of the Select Committee on Narcotics Abuse and Control) presiding.

Present: Representatives Charles B. Rangel, George Miller, Peter W. Rodino, Jr., James H. Scheuer, Walter E. Fauntroy, William J. Hughes, Mel Levine, Benjamin A. Gilman, Lawrence Coughlin, Michael G. Oxley, John G. Rowland of Connecticut, Patricia Schroeder, Sander M. Levin, Lane Evans, Dan Coats, Hamilton Fish, Jr., Frank R. Wolf, and Barbara F. Vucanovich.

Staff present: Select Committee on Narcotics Abuse and Control: John T. Cusack, chief of staff; Elliott A. Brown, minority staff director; George R. Gilbert, staff counsel; Edward H. Jurith, staff counsel; Michael J. Kelley, staff counsel; Catherine M. Chase, finance/administrative officer; James W. Lawrence, minority professional staff; and John S.V. Brown, Metropolitan Police detail; Select Committee on Children, Youth, and Families: Alan J. Stone, staff director and counsel; Ann Rosewater, deputy staff director; Victoria Doyle, staff assistant; Carol Statuto, minority deputy staff director; and Joan Godley, committee clerk.

Chairman RANGEL. The hearing will come to order.

[The opening statement of Chairman Rangel appears on p. 90.]

Chairman RANGEL. I recognize the chairman of the Select Committee on Children, Youth, and Families, Mr. Miller of California.

Chairman MILLER. Mr. Chairman, I want to thank you for joining us in holding these hearings. Crack is a relatively new drug, or certainly the widespread use of crack is new. A derivative of cocaine, it has a devastating impact on our young people and our population generally.

As I'm sure the members of the Select Committee on Narcotics Abuse and Control are well aware, we have an epidemic in this country of drug use. Any particular drug could be drawn into question at any given time. I hope this hearing will become a lightning rod, drawing the attention of the President of the United States to the fact that, whether it is PCP, crack, or cocaine, we are losing the effort to save our children from the devastation of drug use in this country.

There is no disagreement about what approach should be taken. I think every member of this panel understands it requires a comprehensive approach. The tragedy is that there is no portion of our effort in the war against drugs that is properly funded at the Federal level, and the result has been that local efforts have not been able to meet the demand of those who seek to rehabilitate themselves, of those who seek to avoid drug use, or those who are in terrible, terrible trouble because of drug use.

In fact, what we see instead is a dramatic reduction in the resources that should be available, and I would hope that when we leave this hearing this morning it will not be necessary to come back some months from now and pick another particular drug that is devastating on children and families to try to get this administration's attention.

Congress, time and again, has sent legislation to the White House to deal with the drug problem on a multifaceted basis, again, whether eradication, interdiction, education, or the prosecution of those who would deal these drugs to our youth. But we have not seen that same concern or approach picked up by this administration.

Unfortunately for many of our youth, unfortunately for many of our children, it is already too late, and we have lost them to this tragic, tragic devastation.

I know that as Chairman of the select committee on drugs, that you have proposed legislation for education, interdiction, and so forth, and I would hope that your efforts would lead to proper funding of those efforts, because the cost of not doing so has already been far, far too great for American society.

I appreciate the opportunity to participate in these hearings as chairman of the Select Committee on Children, Youth, and Families.

[The prepared statement of Chairman George Miller appears on p. 94.]

Chairman RANGEL. The Chair recognizes Congressman Benjamin Gilman, the ranking minority member on the Select Committee on Narcotics Abuse and Control.

Mr. GILMAN. Thank you, Mr. Chairman.

Mr. Chairman, I certainly welcome the addition to our committee of our distinguished Members from the Select Committee on Children and our Judiciary Committee. This is a problem that needs the best of all of us. It needs the best of the Federal Government, the State governments, the local governments, the community, the church, the families; it needs all of us involved to try to combat this pervasive evil that is eroding the very roots of our society.

We're at an important crossroad in our Nation—the awareness that drug abuse is now epidemic and at the same time that an even deadlier drug is now available for consumption. That drug is crack, and it's sweeping across our country like a tidal wave. It's inexpensive and highly depressive, our young people are using it in all of our metropolitan areas, and our police and law enforcement people are asking us what we are doing about educating our young people about the dangers of this new deadly drug.

I hope that with today's hearing, in bringing some expertise together, we are going to not only focus attention on how critical this problem is but to try to find some new solutions, some more effective ways of handling this problem.

As we all know, the President during the last month has declared narcotics trafficking a national security threat, thereby enabling our military to become involved. We are going to have to focus our attention on how better we can attack this problem that is corrupting governments and killing our young people, and I hope that with today's testimony we are going to take another step forward in this war on drugs.

Thank you, Mr. Chairman.

Chairman RANGEL. The Chair at this time recognizes Congressman Dan Coats, ranking minority member of the Select Committee on Children, Youth, and Families.

Mr. COATS. Thank you, Mr. Chairman. I commend you for holding this hearing today.

We have before us a serious problem, something that I'm not sure any of us have a definitive answer for. We do know that we need to do everything we possibly can in terms of interdiction of the problem, yet we know that, regardless of the effort, regardless of the expenditure, if the demand exists, the supply will be there.

Therefore, it seems that we also need to work on some things that we have been talking about in the Select Committee on Children, Youth, and Families regarding society's values, society's attitudes, the condoning or condemning of some of these practices. Unless we work on those attitudes, and on society's view toward the use of drugs and the impact that it has on our society, we probably aren't going to be very successful.

So I hope that we can derive some answers from the hearing this morning and start on the long road toward dealing with this problem on a successful basis. Again, thank you for convening the hearing.

Chairman RANGEL. Nobody in the Congress has done more than Chairman Peter Rodino in fighting this surge that has hit our Nation. In every administration over the last couple of decades, he has effectively shaped the legislation that each administration, Democrat or Republican, has consistently ignored. It is because of his support in the Congress that our committee is in existence, and the Chair yields to Chairman Rodino as much time as he may consume.

Mr. RODINO. Thank you very much, Mr. Chairman.

I want to applaud you and the chairman of the Select Committee on Children, Youth, and Families, for bringing together these committees this morning.

While I appreciate your kind comments Mr. Chairman, let me say that you and your committee have brought this problem to the attention of the American people. I feel, Mr. Chairman, that we, as a nation, have not yet addressed this problem in the manner which befits it.

While I speak about this present administration and the fact that it has failed to address this problem effectively, nonetheless, I must say that other administrations before this, whether Democrat or Republican, as well, have failed to do so.

The important thing is that this is a problem that is so pervasive, so all-encompassing that I think it requires as much of our resources and our effort as our national defense effort.

The President has called it a national security issue, and yet, Mr. Chairman, I must remind you that several months ago you, I, and other members of the Select Committee and the Judiciary Committee proposed that there be a White House Conference on Drug Abuse and Control to develop a national strategy.

I don't think we are going to be able to deal with this problem unless we employ all of the resources of this Nation to address this problem. I think it is going to take all of the brain power that we have in this Nation to come together, and I think only the President can do it. I think the President must exert his leadership and it must go beyond rhetoric.

It is all well and good that we have the First Lady addressing the people of this Nation from time to time, and I would welcome the President coming out and addressing the Nation about this terrible problem. But unless we bring together the best brain power that we've got, all the resources that we've got, in order to develop a national strategy, then we're not going to be able to deal with it. For that reason, you and I and others proposed legislation calling for a White House Conference on Drug Abuse and Control.

Many of us in a joint letter urged the President to endorse this idea. Instead, I must say that I'm disappointed that on June 2 I merely received a letter from the assistant to the President, Mr. Ball, telling me that they received our letter which we addressed to the President urging that he endorse this legislation, and it was turned over to the President's Deputy Assistant for Drug Abuse Policy.

Mr. Chairman, unless we are able to bring together all of the resources of this Nation, unless President Reagan recognizes the importance of ensuring that we do as much for this problem of drug abuse as we are doing for national defense, I don't think we are going to win this war on drugs, and this is why this morning we find ourselves in another chapter on the war on drugs saying, "My God, what are we going to do now?"

Thank you very much, Mr. Chairman.

[The statement of Mr. Rodino appears on p. 95.]

Chairman RANGEL. Did the President name who that deputy assistant was?

Mr. RODINO. The President did not name him. As a matter of fact, I can't say that the President named him because the letter is from Mr. Ball, the assistant to the President.

You know, we've had these letters before, Mr. Chairman.

Chairman RANGEL. I know, but I thought maybe we had made some progress to determine at least whom he designated the responsibility to. Is there any indication as to whether or not the Assistant Secretary of State for International Narcotics Matters—has that vacancy been filled? Is that in the letter?

Mr. RODINO. The letter is a simple letter acknowledging, very, very briefly, telling me, as you know, both the President and the First Lady are very concerned about the threat which drug abuse poses to the well-being of every nation: It reads "We appreciate your opportunity to review your suggestions for how to help in the fight against drug abuse and will therefore share your remarks—share your remarks—with the President's Deputy Assistant for Drug Abuse Policy. You may be assured that your comments will be given careful consideration."

Chairman RANGEL. That's encouraging.

Mr. RODINO. Let me add, Mr. Chairman, that you and I know that back in the early 1970's we proposed that the President be given authority to cut off aid to those nations that failed to cooperate with us in trying to stop the illicit traffic in drugs.

Mr. Chairman, I must tell you, and you are aware, that notwithstanding the fact that I've made numerous inquiries.

I don't mind telling you, and it's shameful to have to tell you, that it took months before I got a nonreply.

Now that has been going on for a period of time, as you know, and we do have that legislation on our books, and yet it's the same old response: Don't rock the boat.

Chairman RANGEL. The Chair recognizes Mr. Hamilton Fish.

Mr. FISH. Thank you very much, Mr. Chairman. I want to congratulate you on calling these joint hearings.

I certainly agree with what my colleagues have said, the endorsements of the President's statement that narcotics trafficking poses a national security issue. I personally believe it is one that is going to have to be addressed on many fronts, as Congressman Gilman has indicated, and particularly in the source countries themselves.

This morning's hearings on crack are therefore not only timely but of critical importance. Nine months ago, addiction to crack was virtually unheard of, and today it's an epidemic, a plague, that is sweeping the country.

Cocaine claimed the lives of 563 people in 25 major cities last year. That was nearly three times the number of cocaine-related deaths in those cities in 1981. In our city of New York, cocaine is listed as a primary cause of 137 deaths in 1985 compared with only 7 2 years prior to that.

A recent survey of high school and college students conducted by the Institute for Social Research at the University of Michigan states:

> Clearly, this Nation's high school students and other young adults still show a level of involvement with illicit drugs which is greater than can be found in another industrialized nation in the world.

Mr. Chairman, my hope is that today's investigation will shed light on what the Federal Government as well as local and State governments are doing and can do to respond to the growing problem of crack, and, in addition, I hope that we will learn what prevention and treatment approaches are working.

Thank you, Mr. Chairman.

[The statement of Mr. Fish appears on p. 98.]

Chairman RANGEL. Thank you, Congressman.

Is there any Member seeking recognition before we call our first panel?

Mr. Fauntroy.

Mr. FAUNTROY. Mr. Chairman, I would like unanimous consent to enter my opening statement in the record at this point.

Chairman. RANGEL. Without objection.

[The statement of Mr. Fauntroy appears on p. 100.]

Chairman **Rangel**. Mr. Oxley.

Mr. **Oxley**. Thank you, Mr. Chairman. I'll be very brief.

I want to congratulate you also for the timeliness of the hearings and would indicate that, while our hearings have focused on a lot of the problems, the area of crack particularly today is quite poignant because it is a vicious drug. We found out about it really only about 9 months ago in a DEA briefing that was given to this committee, and it's probably indicative of how dangerous it is that even heroin addicts are afraid of crack and how important this is.

I am particularly pleased that the chairman of the Judiciary Committee is with us today, because part of the problem, as we all know, comes from illegal immigration and the transportation of illegal drugs across the border, particularly the Mexican border, as our study in January very clearly pointed out.

I think that while there is a great deal of concern that many of us have as to whether the administration has or has not been strong enough in the drug field, clearly we can do something in the Congress, and that is to pass a very meaningful and tough anti-illegal immigration bill and move it quickly to at least solve a piece of that very vexing puzzle that we have before us. I think it's important that we keep that in mind as we work our way through these hearings, and I again thank the Chair.

[The statement of Mr. Oxley appears on p. 105.]

Chairman **Rangel**. Mr. Hughes.

Mr. **Hughes**. Thank you, Mr. Chairman. I'll be very brief.

I just want to alert the chairman and members that it is the intent of the Subcommittee on Crime to mark up the White House Conference on Drug Abuse legislation next week. I pulled it today because of concerns apparently expressed by the Justice Department. The Justice Department feels that they should not be included in the White House Conference, that law enforcement operations should not be a part of any such conference.

I don't really subscribe to that, because I think that one of the problems that we have had, Mr. Chairman, is that we are looking at the problem piecemeal, instead of trying to pull the entire problem together and look at it from the standpoint of a national strategy. But it's my hope to mark it up on Tuesday.

I want to say that we haven't had a White House Conference on Drug Abuse, according to Chairman Rodino, since President Kennedy convened a White House Conference on Drug Abuse back in the 1960's, and of course then it was small problem compared to the scope of the problem today.

Thank you, Mr. Chairman.

Chairman **Rangel**. Thank you, and I do hope that some of the people in the audience might try to give us some support in this bipartisan effort to focus attention in the White House with the support of the Congress in this area.

Mr. Levine.

Mr. **Levine**. Thank you, Mr. Chairman.

I, too, want to compliment you and Chairman Miller and Chairman Rodino for the leadership that you have all shown in convening these joint hearings which are extraordinarily important.

As you know, Mr. Chairman, I represent a part of southern California, and we have learned in southern California over the course of the past several years of the extraordinary urgency of the crack epidemic as part of the general drug epidemic in our area of the country as well.

Crack has been available in southern California now for about 5 years, resulting in the increasing crime and medical emergencies being recognized more recently in other parts of the country.

In parts of Los Angeles, drug buyers can purchase crack without even leaving their cars. It was recently reported in the Los Angeles Times, for example, that drug dealers in my area, my congressional district, were using a stolen stop sign to flag down cars to make additional drug sales. In another area of Los Angeles, dealers set up a trash can slalom course to slow traffic and provide more opportunities for drug sales.

We have learned that local police are having a particularly difficult time dealing with the crack explosion. When they are successful in closing down the drug traffic in one area of town, the drug market simply moves and overwhelms another neighborhood.

Mr. Chairman, as we have already heard from some of the other Members, unfortunately for all of the rhetoric that we have heard with regard to drug abuse, thus far this administration has simply refused to take the necessary action to deal with this problem, despite a variety of legislative attempts to focus on this area of drug abuse much more aggressively than the administration has been willing to do.

So I join with the other Members in hoping that this joint hearing will help to bring about the kind of attention and focus that I think on a bipartisan basis the Members of both Houses so urgently believe is necessary.

Thank you, Mr. Chairman.

[The statement of Mr. Levine appears on p. 106.]

Chairman **Rangel**. Congresswoman Schroeder.

Mrs. **Schroeder**. Thank you, Mr. Chairman.

I just wanted to be brief but compliment you and the other people, because I, as the mother of two teenagers, spend an awful lot of time talking to teenagers about how this gets started.

I think at the very beginning you pointed out the tremendous lack of education. I met with some teenagers just recently who have been going to school in this country for a year on an exchange program. They were all from Europe. I said, "Why do we have incredible drug problems with our teenagers, and you don't have it in Europe?" and they said, "Education."

I think if you don't believe that, look how far this country has moved on seat belts; look how far it has moved on smoking, look how far it has moved on all sorts of things where we have educated, and yet in the last 4 years we have cut our drug education program.

So I think education is the cheapest thing we can do. If we can prevent having addicts, then we really stop a lot of this. So much of the focus is: What do we do after they become addicts? Let us listen to young people who say they get into this because they think it's recreational, and then they find, oh, it's way beyond recreational.

But we are not doing a good job, and I think your focus on education and moving in that direction is really where we have got to be. I am just appalled that we have been cutting rather than adding as we see the problem grow, and I thank you very much for pointing that out.

Chairman RANGEL. Mr. Coughlin.

Mr. COUGHLIN. Thank you, Mr. Chairman.

For more than a year, of course, under your leadership the select committee has been calling attention to the fact that we have a unique confluence of events, one in which there is an impression that cocaine is harmless, where we know cocaine kills, where there is evidence that it is very highly addictive, and at the same time what used to be an executive high, now the price is going down and it is becoming available to people from all income levels and of all ages.

Certainly I want to commend the First Lady of the Nation, Mrs. Reagan, for the effort that she has made in a grassroots effort in drug abuse, and I thank you for the opportunity.

Chairman RANGEL. Thank you, Mr. Coughlin.

The Chair recognizes Chairman Miller for purposes of calling our first panel.

Chairman MILLER. Thank you, Mr. Chairman.

Our first panel this morning will be made up of Kevin Grevey, a former player with the Washington Bullets and now the executive director of "Off Season"; and Bill Scheu, who is a player-coach for a program of the U.S. Legends Basketball team and a director of the Youth Sports Drug Awareness Program; Ms. Lee Ann Bonanno, who is a recovering crack user from the Bronx in New York; and she will be accompanied by her mother, Janet Bonanno.

We would like to welcome this panel. Your entire statements will be put in the record. You may proceed in the manner in which you are most comfortable.

We are interested in what you have to tell us. The Select Committee on Children, Youth, and Families has tried in each and every one of its hearings not only to hear from those people who are national experts, but to try as well to look to communities to see what various communities and what programs are available, and what they are attempting to do as a localized effort, and also to hear from families that have been directly involved in the problems that have been the subject matter of our hearings, and I think the participants in this first panel reflect that.

Kevin, we will start with you.

TESTIMONY OF KEVIN GREVEY, FORMER PLAYER, WASHINGTON BULLETS BASKETBALL TEAM, AND PRESIDENT, OFF SEASON, INC.

Mr. GREVEY. Thank you.

I appreciate the opportunity to testify before the House Select Committee on Narcotics Abuse and Control and the House Select Committee on Children, Youth, and Families regarding drug abuse and associated problems, especially cocaine in its various popular forms such as crack, crank, and black rock.

I am Kevin Grevey. I have just completed 10 years in the National Basketball Association. Since my retirement this past season, I have decided, through my role as president of Off Season, Inc., to concentrate on activities involving professional athletes to help address public needs.

Off Season is a Washington, DC, based nonprofit corporation established in 1977 for this purpose. Our present emphasis is to help combat drug abuse, both among athletes and in society at large, especially among youth.

Drug abuse among teenagers has reached alarming proportions, particularly with crack and other forms of cocaine which have become readily available and relatively inexpensive.

In my travels across the country performing basketball clinics and workshops, I have had the opportunity to work with many young athletes in their schools, and I am saddened to tell you how I had to change the focus of my instruction over the years from the fundamentals of basketball, such as shooting, and dribbling, and rebounding, and passing, to the hazards of using drugs. In my opinion, administrators, teachers, and coaches are now faced with their greatest task ever, and that is educating students about drugs.

Crack and other forms of cocaine are not just ruining young minds and athletic careers, they are taking lives at an alarming rate. Lately, with the most recent cocaine-induced deaths of Len Bias and Don Rogers, a lot of attention has been focused in professional and amateur sports. No question about it, there is a serious problem in professional sports.

I saw teammates who had trouble performing because of cocaine use and some ultimately destroying their careers. The sad thing is that many of these athletes' cocaine problems didn't start with the new-found success and wealth of professional sports, like most people want to believe, nor did they start in their college years. For some, their exposure to drugs came as early in their lives as junior high school or even grade school. Drug abuse today is a problem that has no boundaries—not age, sex, or socioeconomic background.

It has been very painful for me to see other players ruin their careers through drug abuse. It is equally painful to see our youth—athletes or not—risk their lives with such menaces as crack and other drugs.

As I mentioned, Off Season is designed to help athletes to help society to address social ills and meet public service needs. We recognize that athletes are not immune from society's problems, and so we are faced with drug abuse in our own backyard, and we must work diligently to eradicate it.

On the other hand, we recognize that many professional and amateur athletes who have maintained a drug free and positive lifestyle can serve as role models influencing youth to avoid drugs or to give them up.

We see athletes as playing a vital role, along with coaches, teachers, counselors, community organizations, and Government agencies, to educate youth about the dangers of drug abuse and to encourage and guide them to productive living on whatever paths they choose to walk.

[The statement of Mr. Grevey appears on p. 108.]

Chairman MILLER. Thank you.

Bill.

TESTIMONY OF WILLIAM SCHEU, PLAYER-COACH, USA LEGENDS BASKETBALL TEAM, AND DIRECTOR, YOUTH SPORTS DRUG AWARENESS PROGRAM

Mr. SCHEU. My name is Bill Scheu, and I'm the current player-coach of the U.S.A. Legends Basketball Team, which is comprised of former NBA Hall of Famers and all pros that are selected positive role models, and we do quite a bit of work throughout the country with charities. We have had two or three basketball games on Capitol Hill for major charities including Congressmen, Senators, and players, which seemed to be a lot of fun as well as accomplishing our major goals.

I wanted to share some of my experiences with kids and the Youth Sports Drug Awareness Program that I have been working on for the last 6 months. It all started approximately 2 years ago. Our U.S.A. All-Pro Legends Basketball Team traveled to Palm Beach County, FL, and our sports promotion consisted of a celebrity basketball game benefiting the Adam Walsh Foundation.

With a few hours before our plane departure, we stopped at a kids' halfway house and had a sports rap session with questions and answers. After we had spoken about sports experiences and events, the kids became very relaxed with us and started gearing their questions toward drug issues.

I was totally shocked, for I was unaware of some of the current situations of our Nation's youth. These kids openly talked about marijuana and cocaine—this is 2 years ago now—the uses, the effects, and the money to obtain them. Strangely enough, these kids ranged from approximately second to sixth grade, which totally caught me off guard. They knew more information about drugs than I did.

After that incident, it prompted us into talking to many kids in camp, clinic, and sport situations about drugs at the early ages. I strongly believe in today's fast-paced world people are either unaware or simply just don't want to be bothered.

I have been studying the drug problem our Nation faces for 6 to 8 months now from many different resources. A common problem seems to be that the various programs and efforts are headed in many different directions without a focal point.

Two of my most recent examples with youth sport situations have been Len Bias and two international basketball players from France. The Len Bias tragedy has affected all of us, locally as well as internationally. More and more kids are asking me: "Why did he do it?" "What were his problems?" "He was so stupid."

This event has made many kids and adults aware and afraid that drugs are now killing, as opposed to all other information heard.

The marijuana produced now is 10 times stronger than 5 years ago, and the newest form of cocaine, crack, is so inexpensive—$5 to $10—and a lot more powerful. If used one to three times, you can become totally addicted.

The second recent situation, on Thursday, July 10, I met in Congressman Mike Oxley's office with two international French athletes visiting the country with the USIA exchange program. Their first question concerned Len Bias and the use of drugs in our country. In my estimation, this was an international embarrassment.

Just last summer, I traveled to Europe and Africa with the USIA as a goodwill ambassador and sports coach. A lot of questions were also geared toward American drug problems in sports. It was sensed that in most other countries they don't have these problems or not to our extent.

We are a world leader and seemingly have a large problem and a national problem that's growing daily. Consequently, the Len Bias tragedy has touched us from many different perspectives.

I first met Len when he was in the seventh grade and, working with many gifted youth around the country, have found that they are exposed to a fast track at even an early age. The pressure on these kids can be immense. Grades, favors, limelight, attention, instant gratification are all key factors. After a while, you expect to get anything you want.

With these forms of instant, constant highs, where does this leave the person down the road? Our Youth Sports Drug Awareness Program was first introduced and formulated as a team effort with one of our Nation's finest school systems, Palm Beach County, as well as its brilliant innovator, security educator, Mr. John McKenzie.

Currently, this week, Mr. McKenzie is nationally hosting a security convention in West Palm Beach to prepare and share the most up-to-date information and strategies. Mr. McKenzie, his innovative staff, and myself formulated that a strong preventative education program followed up by a uniform national cohesive effort would have a great effect concerning drugs in the United States today by minimizing the demand through preventative education while also trying to regulate the supply.

Each school system that we work with has its own different philosophy and has to be treated as such. The Palm Beach philosophy currently is: "Help our children get naturally high." The School Board of Palm Beach County Department of Security has also taken the first step with its Naturally High Drug Education Prevention Program. The school board believes that, given opportunities to see positive alternatives to drug highs, our young people will choose the natural highs.

Children are inevitably exposed at an early age to drug use. The likelihood that abuse can be reduced despite this exposure depends on accurate information and programs geared toward building self-esteem and providing positive role models. With your help, these programs can convince our children that it's OK to say no and to be drug-free.

We believe that the preventative education program has to start at kindergarten through the sixth grade en route to the 12th grade. These are the formative years where character, personality, attitudes, and values are formulated, and some experts feel that preventative education after the first through sixth grade is really too late.

The early programs should stress the kids' understanding of different types of highs and the consequences. The so-called idolized positive role models can show kids the glamor side of drugs as viewed through today's mirror image of society and not so glamorous end result as Bias and Rogers. This promotes the self-awareness concept from these tragedies. As I heard from a 7-year-old last week say, "Mommy, you can really die from this."

Our sports program is trying to open the door, followed up by many reinforcements. These programs for the young will educate and provide good decisionmaking skills for saying no to drugs, also to assist forming student groups that support a drug-free lifestyle. Former and present professional athletes who are positive role models through training and education can also help motivate adults and present viable drug-free role models for young youth and people of today.

I believe that preventative education within the schools will prompt the best results for youth and awareness in the future as well as a cohesive effort by all the other team members playing the game.

Thank you.

[The one-page article appears on p. 111.]

Chairman MILLER. Thank you.

Next we will hear from Lee Ann Bonanno.

TESTIMONY OF LEE ANN BONANNO, RECOVERING CRACK USER, BRONX, NY

Ms. LEE ANN BONANNO. My name is Lee Ann Bonanno. I'm 20 years old. I live in the Bronx, NY.

I am in a drug rehabilitation program called Daytop Village. I have been there for approximately a year. I entered Daytop Village in August 1985 because I had finally, after 5½ years of getting high and destroying myself and my family, admitted that I had a serious drug problem. I came to the end of my road.

After trying to deny the problem for so long, I knew I had to tell someone in order to get help that I needed. I didn't have the strength to do it on my own.

On July 10, 1985, I woke up and took a good look at myself in the mirror, and I saw someone I didn't even know; that really scared me. I ran to my aunt's house and asked for help. From there my parents were called, and it was all out in the open.

My father came over, and I thought he would scream and yell at me, but I was wrong. He came in the door and said, "Thank God you finally admitted it; now we can get the help you need."

For those 5½ years, my parents knew I was getting high, but every time they confronted me with the issue I would either run away from home or I'd lie to them. I became such a good liar because of the use of drugs.

At this time, I was going through withdrawal symptoms. I was a nervous wreck, my eyes looked terrible, and I couldn't sleep. The only thing I could keep down in my stomach was water and Italian ice. My looks totally changed from getting high. I looked like a pale human skeleton.

My parents kept a close watch over me that night. They knew I was ready for help, and they didn't want me to give up.

The next day, my parents and I went to see a psychiatrist. The psychiatrist told me that I should have never stopped taking Valium cold turkey because I could have a seizure and die. Valium was the drug of my choice, and I was taking approximately 150 milligrams a day or more.

The psychiatrist tried to detoxify me at home at the time by giving me three Valium the first day and two per day for a week. That didn't work. The second day of trying this, I was taking a shower and I got sick. I threw up, and I noticed I was throwing up blood. I screamed for my mother, and she rushed me to a hospital. When we got to the hospital, I couldn't stand up, never mind walk. I had to be taken into the hospital by a wheelchair.

My mother called up the psychiatrist, and she came right over. The hospital couldn't do anything for me because they didn't have a detoxification unit. The psychiatrist called Westchester County Medical Center, and I went there, and I was examined and admitted to the detoxification ward. I spent 5 days there.

Those 5 days were so awful and unbelievable. The changes my body was going through were unbearable, but I did it. I wanted that poison, those Valiums, out of my system.

When I left detox, my psychiatrist thought it best for me to spend some time in a psychiatric hospital to get my thoughts and mind on the right track. I admitted myself into St. Vincent's Psychiatric Hospital, where I spent 2 weeks. When I was there, I knew I couldn't go home without some kind of reinforcement. I was afraid I would go back to using drugs.

So I spoke to my mother on the phone and explained to her the way I felt. She was one step ahead of me; she already spoke to a counselor at Daytop Village. I asked her to make an appointment for me as soon as possible. The appointment was for the day I was released from the hospital.

I went to Daytop, and I had my interview. The counselor who spoke to me told me to give considerable thought about going into residential treatment, which is 24 hours. I didn't want that, because I was scared of it. I didn't want to be away from my family. I chose to be in treatment in the outreach. Some people said I chose the hard way, but I feel I chose the right way for myself.

I started treatment August 13, 1985. I started in the day-care program, which is Monday to Friday, 9 to 5, and Saturdays from 10 to 3. There are groups every day and individual counseling. There is also a school for the residents who want their high school diploma or their GED.

I went to day-care for 9½ months. Then I presented myself for the next phase of the program, which is second stage. I felt I was ready to go on with my treatment.

The counselor spoke to me and then spoke to my parents. I am now in second stage, working toward my graduation. In second stage, I go to groups Monday and Thursday nights, 6:30 to 8:30. I also go to school 5 days a week. I go to Robert Fiance School of Hair Design. It was always the career of my choice, but I never had the confidence to go for it until now.

When I entered treatment, I was a liar, thief, manipulator, and very immature, all the classic symptoms of a drug addict. One of the hardest things for me to do was to open up to people when it involved my emotions. I used to stuff everything down. I was very good at helping everyone else. It just made it easy for me not to have anyone confront me or for me to take a look at myself. I was unable to trust anyone with my thoughts or feelings. I resented anyone who tried to have me open up. I ran from them. That included my family. Any time my mother or father got close to the truth of my drug problem, I would leave home until the problem would be aside, and I would be allowed home, and my parents would be so happy to see me, the problem would be unresolved.

Even in the outreach for the first 2½ months, I went through the motions and did what was expected of me. Eventually, everything caught up with me. As the counselors say, they will give you enough rope to hang yourself, and I did, because I would take advantage of that they were there to help me and for me to talk to.

It took 3 weeks of confrontation from the counselors and the residents to have me open up some. I started allowing myself to hear what was being said and accept it was true. I finally stopped running and allowed the concept to filter in.

In January 1986, the counselors felt it would be helpful for me if I was put into a marathon. A marathon is a long extended group which can last from 3 to 5 days, and you let everything out in the open and take a good hard look at yourself.

In the marathon, there were 11 other residents and 2 counselors. I really didn't trust anyone that I was with. During the marathon, I knew it was time to start trusting and to trust the environment around me, also to open myself up completely, which I did. I also made true friends. I never had friends like that before. If I didn't open up then in the marathon, I'm not sure where I would be now.

When I left the marathon, it felt like a weight was lifted off of me. It was like a new person was emerging from myself. The change was noticed by everyone. It gave my parents the hope and trust that they had lost for me. For the first time in a long time, I could be myself and not be afraid of how people would look at me. I didn't run from things any more, I dealt with them. That was the point I really started changing and becoming Lee Ann, the individual, the winner.

I started with drugs at the age of 12. I smoked a joint with a friend. I really didn't like the way it made me feel, so I didn't continue with it. When I was 14 years old, I started hanging out with the wrong crowd. They all used one drug or another, and they would offer them to me. I didn't want to say no, because I wanted to be cool.

It started out with marijuana and drinking alcohol. After a while, it progressed to mescaline, ups, downs, all types of pills, and cocaine. I was 15 years old when I first tried cocaine. I was at a party, and everybody was using it but me because I was afraid of it. I felt like an outsider because I wasn't sniffing like they were.

After a while of everyone saying, "Come on, try it," I did. After that night, I was using cocaine for 4 years. I used to sell cocaine, but I used to sniff more than I sold, so I stopped selling it.

When I was 17 years old was when my Valium addiction started the "forget-me-not" pills. All my problems seemed to disappear and nothing bothered me. When I was 18½, I tried crack. Crack was in a cigarette. The high was a different high than when I sniffed cocaine. I didn't get the nosebleeds from smoking crack, and I liked that. The high made me feel like I was floating and gave me a head rush, and nothing would bother me when I felt like that.

If someone annoyed me when I was high on crack, I would start a fight with them, or I felt like I wanted to kill them. Crack made me a very violent person, something like Dr. Jekyll and Mr. Hyde. I began to rob and steal. I robbed gas stations for money. I would even rip off the dealers to get the crack.

A lot of problems started to develop at home. The detectives were out looking for me because I was involved with an assault. I left home and lived in the woods for 2 weeks because of that. I stole food from the supermarket so I could eat when I was in the woods, and I also stole beer from the delis. When I came home, everything was squashed, and the person dropped the charges against the people involved.

Before crack was sold as crack, the people and myself used to cook up our own cocaine so we could smoke it. I have smoked crack in cigarettes, pipes, and rolled it up with marijuana. From all the cocaine I have sniffed and all the crack I've smoked, I developed a heart murmur. It's true what they say, drugs are a slow suicide. If I would have continued with drugs, I would have been dead or in jail. Thank God I stopped when I did.

I got involved with drugs for many reasons; peer pressure was one main factor, not dealing with my problems, and not speaking about them. My parents were always there for me, but I refused to see them that way, I always thought that they were my enemy. Not dealing with problems, instead I ran from them by getting high. I wanted to belong with what I thought was the in crowd.

Daytop has given me back myself. It's a self-help program, man helping man who helps himself. Daytop has also helped my parents with dealing with having a child with a drug problem. My parents attend groups once a week. It has helped them a great deal. My brother, who is 19 years old, went to sibling groups. It let him get out his feelings of having a sister who was a drug abuser. My family and I have the best relationship ever. We are very open with each other, and we talk about whatever is bothering us. We are united again. When you are in treatment and your family gets involved, treatment is easier because they understand what you are going through.

Daytop has helped me so much to change and to live and lead a drug-free life. I have a whole new outlook on myself and life. I'm the winner. I finally can say that Lee Ann is an individual and a special and important person. I also know the true meaning of friendship.

Before I was in the program, I never had friends. The only friends I had were people out in the street that, if I was getting high with them, they considered to be my friends. In Daytop, I can talk to people, and they can understand me and I understand them.

Drug problems or addictions are not only with the poor or minorities, but it's with everyone. Without the proper funding by the Government, places like Daytop Village, Inc., will fade from existence, and then there will be no help available, and that just isn't fair. The drug problem has been so far spread, and more and more young ones are easily becoming involved. What is the future America going to be like? Something has to be done. It has to start with the Government.

It's not fair to tell someone, "I'm sorry I can't help you because there is no way to get a bed because the facility is too overpopulated." It's not fair to tell them to wait 3 months until a bed is vacant. God forbid they die in those 3 months. We need help desperately. I know; I was there myself.

I also work with the SPECDA Program with the New York City Police Department. What SPECDA stands for is School Program To Control and Prevent Drug Abuse, and we have only been working with one district. I know the city definitely needs funds, because we need more programs like this.

I work with the fifth and sixth graders, and these kids write me letters and send them to my program. When I receive them I read them, and they touch me. One little boy's sister was a drug addict, and she overdosed, and the little boy didn't know what she was going through until I came into the classroom and I spoke to them, and now he understands what his sister went through. I feel that the schools should have more programs like the SPECDA Program.

[The statement of Ms. Bonanno appears on p. 112.]

Chairman MILLER. Thank you very much, Lee Ann, for your testimony.

Janet.

Janet, to the extent that you can summarize your testimony a little bit, it would be helpful to the committee, so we will have time for questions.

TESTIMONY OF JANET BONANNO, PARENT, BRONX, NY

Mrs. JANET BONANNO. OK. My name is Janet Bonanno. I reside in the Bronx. I am the mother of a recovering drug abuser. I am here to try and make people aware of how widespread and devastating the misuse of drugs, especially crack, are to the user, the families, the entire community.

My daughter, Lee Ann, started using drugs at around the age of 14. It started off innocently enough, she thought, with marijuana. But once into the drug scene, her habits, lifestyle, and personality changed drastically. At that time, she began seeing a fellow who was 17. Through him and his friends, drugs became a way of life for her.

At the time, we knew of him from the neighborhood and tried to rationalize that his actions were caused by a family that showed no concern for his well-being; there was never any supervision. At the time, I felt my daughter's attitude and behavior were due to this new lifestyle, never realizing that this was the beginning stages of drug usage.

The relationship became very unhealthy. My husband and I tried to separate my daughter and this fellow. He came to my house with a shotgun and attempted to murder my husband. We pursued the matter in court. His parents had him out on bail. While he was out on bail, he came back to my home with a pellet gun and shot up my husband's van, which was parked outside my home. He blew out the windows and shot up the body of the van. I then went to court to try and obtain an order of protection for myself and my family. I did obtain it. The order was worthless. He would come around, harass us, I would call my local police station, and they would tell me he was not in violation of this.

In the interim, my daughter left home and went to live with this fellow and his family. At the time, she was 17 years of age—my daughter. We called the assistant D.A. who was handling this court case for us, and he called family court to find out what legal right we had with our daughter, and he was told that a child who was 16½ years old had the legal right to leave home and school without parents' consent, but they were unable to admit themselves for medical treatment because they were under 18. This was a law that made no sense. I felt as if I were knocked flat by the news. After loving and caring for my daughter for 17 years, I had no legal right to see her unless she wanted me to.

I tried to keep some communication open with my daughter, which caused personal problems between my husband, son, and myself, but I knew my daughter's life would depend on someone being there when she wanted help. So whatever sacrifice that had to be made, I believe it certainly was worth it.

When the court case was resolved, with him being sentenced to 18 months in prison, my daughter was no longer wanted or needed by his family, and she returned home.

I knew deep inside my daughter still had a drug problem, but I still was not able to accept it, and when my daughter wanted to go to school to be a medical assistant, I was still hoping maybe this would be the answer. Needless to say, it wasn't. It only made it more accessible for her. She was able to get a better knowledge of drugs for the wrong reason. She was unable to hold a job for any considerable length of time.

By this time, she had already become involved with another neighborhood drug user and formed a relationship with him. From that point on, her mental, emotional, and physical well-being deteriorated rapidly. We could no longer deny what we could see happening to our daughter, but by law we were still helpless to do anything to save her. Our only recourse was to pray that she would be taken care of until she would want to be helped.

Finally, last July, after years of worry and torment, my daughter admitted that she was using drugs and went to my sister and her husband to ask for help. Needless to say, my husband and I were overjoyed that finally we could do something to help her. We felt that at last we were getting our daughter back.

My daughter was sent to a detox center, which cost $6,000 for 5 days, and from there was sent to a psychiatric hospital for 2 weeks, which cost $10,000. Luckily, my daughter was still eligible under my husband's health coverage. This paid for most of the cost. The rest my husband had to assume.

During her hospital stay, she applied for medical assistance from the city of New York. We still have never heard the outcome of her application even though we have complied with all their requirements.

While my daughter was still hospitalized, she realized that when she was released she would need some type of backup reinforcement to stay away from drugs. I suggested Daytop Village as a solution to the problem. Lee Ann entered Daytop when she was discharged from the hospital, and she still is with them until the present time. I knew it was going to be a long, hard road ahead for my daughter, but with her family, Daytop, and her own determination, half the battle was won.

Lee Ann is now working toward her graduation from Daytop. Upon her graduation from Daytop, Lee Ann would like to work with Daytop sibling groups in her spare time.

I feel the drug problem has been around for many, many years and the only noticeable change is that it is more publicized, but nothing is being done to crack down on drug dealers and profiteers. Laws were passed regarding them but are never enforced.

With all the so-called enlightenment about our country's drug problem, unless the parents can assume the cost or the user is entitled to Medicaid, the help is still very scarce. There are far too many free or affordable drug rehabilitation programs. I am quite sure the moneys allotted for special forces who do little more than observe drug transactions and give statistics could be better used in funding drug rehabilitation centers. These drug rehabilitation centers, such as Daytop, have returned to society productive, functioning, responsible human beings.

[The statement of Mrs. Bonanno appears on p. 119.]

Chairman **Miller**. Thank you very much.

Mr. Chairman.

Chairman **Rangel**. I'd just like to say, it takes a lot of courage for you and your daughter to give this type of testimony, and I do hope you can take some small comfort in knowing that by giving that type of testimony it should make it possible for other youngsters to avoid making the same type of mistakes, and the Chair and the committee are aware of the great work that Daytop is doing as well as the reduction in funds in which they have been forced to operate.

I would just like to ask one question of the panel. As Congressman Ben Gilman pointed out, we have an $18 billion Federal education budget, of which only $3 million is allocated for drug prevention. The reason for that is that Secretary of Education Bennett believes that the Federal policy should be what he describes as zero tolerance, which means kick the abuser out of school. When asked, what do you do before? or what do you do afterward? it is his opinion not only that it is a local or State problem but that there should be no mandatory Federal educational programs.

Could I get a comment from the panel as to whether or not you believe that your Federal Government should be involved in a Federal program or at least give assistance to local and State educational systems?

Mr. Scheu.

Mr. **Scheu**. I think there should be quite a bit of money to be used for the Federal programs. In fact, we have gone a different route. People have approached me from corporations, and it seems to be a lot easier to do that than the reverse. So I'm very much for the Federal—you know, to be funded.

Chairman **Rangel**. Would anyone else like to make a comment on that, because we do have legislation, and we do think we can get support of the Congress, but if this idea that it's a local problem prevails, then of course we won't even be successful in the Congress.

Mr. **Grevey**. I think most definitely the Federal Government has got to get involved, because there have been implemented programs on the local level, there have been things done in the communities, and it's got to be a unified effort, and I think it should start with a statement from the Government that, hey, we're going to do something about it, we're going to get involved and make a true commitment.

I mean we can make commitments against terrorism, we can make commitments against—I think, which is a trivial thing—smoking and some of these other things that were pointed out. This is a major problem.

We can talk about this for another week and give testimonies of former drug addicts and athletes getting involved, and so on. It all makes an impact, but it's got to start with the leadership, and it has got to be then filtered down from there.

We can do all we can. Me, as an athlete, getting another 12 or 15 athletes going into the school systems and talking about these problems, is good; Bill Scheu's program is good; and all the other programs that are out there; but we aren't going to make an impact; let's face it, we're losing ground now.

So we will try to do our part, and we'll make conversation with these young students, but the Government has got to do their part, and they have got to make a true commitment, a statement, and then we will follow the lead.

Chairman **Rangel**. Ms. Bonanno.

Ms. **Lee Ann Bonanno**. Maybe if there were programs like this when I was younger and I was in school, maybe I would have never turned up being a drug addict; maybe I would have had some insight of all the negative factors of drug abuse—what it can do to you, what it does to your family. That's what I'm trying to do now. I go on my own free will with Daytop, and I go to speak to schools all over New York. But we need a program that doesn't just go once a year, maybe a couple of times a week, or even have a program in the school.

Chairman **Rangel**. The program that you mentioned in the New York school system, that's sponsored by the New York City Police Department, isn't it?

Ms. **Lee Ann Bonanno**. Yes.

Chairman **Rangel**. It's ironic that we depend on the leadership in education from our law enforcement while the Secretary is emphasizing law enforcement rather than education.

Mrs. Bonanno.

Mrs. **Janet Bonanno**. I just agree with everything that has been said here. I just feel that it's time to stop talking about it and time to start doing something about it. It's been around forever, and it's just getting worse. We are losing our youth. I think the Government just has to stop talking and start acting.

Chairman **Rangel**. Who is seeking recognition for purposes of inquiry?

Chairman Miller.

Chairman **Miller**. Lee Ann, you nodded your head when one of the members of the panel was talking about the need for an educational effort. He said K through sixth, and you started to nod your head.

In a recent hearing on drug addiction during pregnancy, a number of people told us that they felt that we ought to start dealing with this issue in Head Start—very young children.

You work with fourth, fifth, and sixth graders, and I just wonder if you could describe what you think of their receptivity, whether we can teach them a set of values and the dangers of drugs—if you think we can start that young, given your experience with it, because more and more experts are telling us they think we ought to be in kindergarten and Head Start, starting to explain the down side of drug use to these children.

Ms. **Lee Ann Bonanno**. You have to start when they are very young. I mean the fifth and sixth graders know more about drugs than I know about drugs, and that shocked me because I was dealing with them for 5½ years, and they are so little.

There are kids in the program 12 years old, coming in the program because of crack addiction, and all the schools do is kick them out because they have a drug problem. Or maybe if they had prevention before, maybe they wouldn't be where they are. You know, you have to start very young with the kids today because they are smarter than a lot of us.

Chairman **Miller**. Thank you.

Chairman **Rangel**. Mr. Coats.

Mr. **Coats**. Thank you, Mr. Chairman.

Mr. Scheu and Mr. Grevey, I wonder if you could comment on this. I commend both your efforts regarding athletes in pro sports. I'm curious, though, that there has been so much involvement of drugs in the pro sports, because it's almost a contradiction. Our very finest athletes make it to the pro level. Obviously, their present, their future, their economic security is dependent on them staying healthy, whether it's avoiding injury in the actual contest that they are involved in or keeping their body healthy.

Has there been a myth prevalent in sports that drugs and sports mix and you can maintain a pro career and still do drugs? Has the Len Bias death done anything to explode that myth? What is the attitude? How can an athlete whose life depends on his health fool around and get involved in drugs and take that risk? Why would anybody take that risk?

Mr. **Grevey**. Sports just mirror society, as was mentioned by me. Like I said, there is no question that these role models, these athletes, doing drugs has a terrible effect on society as it filters down to the young athletes and young people who emulate and try to emulate these sports figures.

I know, from playing, to answer one part of your question, no, I don't think an athlete can take a drug and perform to his optimum ability; it can't be done.

Mr. **Coats**. But a lot of athletes must think they can.

Mr. **Grevey**. That's the false premise. That's why people lie and steal and do things when they are doing drugs. They think that they can do something that's really not true.

I'll give a personal example. John Lucas, who has had a terrible drug problem throughout his whole career and is not playing any longer, was a team-mate of mine with the Washington Bullets. John is just a terrific person, a great guy. He was a team leader; he was a community leader—a wonderful family. You would think he would be completely immune from a problem, but it started to happen.

As one of his team-mates, we would come in the locker room; John would come in, he would be all wired, we knew it immediately, and he would look at us, and he would plead with one of his team-mates. He pleaded with me a couple of times; he said, "Kevin, I need help; I'm freaking out," he said, "I can't control myself," and he said, "Tonight, you bring the ball up the floor;" he said, "I don't think I can handle the ball tonight at the point guard position; you bring the ball up the floor." I said, "John, I'm a shooting guard." He said, "Kevin, you've got to help me; just help me tonight."

So it was tearing me up. Other team-mates were talking about it, saying, "Man, John is really losing it here," and it was destroying our team, it was destroying the feelings that we had among our group, and our team was not successful.

There were other guys on the team who were having problems, and there were other players across the league; in every league, they were having those problems, and ours wasn't unique.

You wanted to help him, but what could you do? Really, what could we do? We tried to talk with him, and the problems just continued, and now he's out of the league, but he's lucky, he didn't kill himself, but he is out of the league.

These things are happening in sports today, and I think professional sports now are taking a position, and a strong position, that there has got to be some control here. Some sports now, professional football most recently, have mandatory testing to try to eliminate the drugs in sports.

Mr. **Coats**. What kind of a message does it send back to kids when the players sue management, when NFL management tries to take a stand and say, "We're going to enforce drugs in pro football," and the players turn around and say, "You're violating our civil rights, and we're going to sue you." What kind of message does that send?

Mr. **Grevey**. You know, as strong as I feel about this, I still have a hard time, though, with mandatory testing, personally. I think it is against the free rights. I think that as an athlete, when I would have a bad game, the management looks down on you, and, boy, they're ready to hang you.

It's a very tenuous thing, playing professional sports. If you're paid $300,000 a year, you'd better perform at $300,000 or better, and if you perform at $100,000 for more than 1 week in a row, it's going to open up all kinds of things. I've seen management weasel out of contracts with athletes for a lot less than drug abuse.

Mr. **Coats**. So the fear is that it will be used as a way to weed out athletes for other reasons.

Mr. **Grevey**. That part of it scares me. However, no one has come up with anything yet. Mandatory testing might be the way, I don't know, but, just the same, if the athletes—the player association agrees with the management, great, everybody is going to live by it, fine, but there are still some problems with that mandatory testing, the harassment aspect of it.

Mr. **Coats**. Earlier during the discussion, there was talk about the Government taking the lead, but I think someone made the statement along the line that it has to be a unified effort. Isn't this something that we all have to get involved in? Don't people have to start standing up and saying no? Don't pro team owners have to say, "No drugs on this team"? Don't schools have to start saying, "No drugs in this school"?

I was listening to National Public Radio over the weekend, an academic debate over Secretary Bennett's simple request that college presidents write their students and say there aren't going to be any drugs on campus this fall, and all kinds of gobbledygook coming back from college presidents, saying, "Oh, we couldn't do that; we couldn't send a letter to kids saying there aren't going to be drugs on campus; that would violate their rights." I mean, "This is academic freedom, and we have other programs," and so forth and so on.

If they can't do that, if they can't send a letter out or tell their students at the first assembly that there will be no drugs in school, how are we going to impose a mandatory Federal program saying, "You will teach this; you will do that" when we get all these academicians, college presidents, and school principals coming back and saying, "Oh, well, that wouldn't be proper"?

Isn't that kind of attitude that we can't be tough, we can't say no, we can't have somebody stand up and say there won't be drugs in this corporation, there won't be drugs on this ball club, there won't be drugs in the American League, there won't be drugs in this school—isn't that the kind of thing, that unified effort, that takes place not just at the Federal level but at the State level, the local level, in corporations, in schools, all across our society? Isn't that what is going to bring about a change? Because if there is a permissive attitude that, "Well, maybe we've got to let that person have their rights, we can't force that," then we're just going to continue with this attitude.

Isn't that the kind of unified effort we need? Am I wrong there?

Mr. **Grevey**. No, I think you're right. What you mention is that everybody is pulling in different directions. You have got some people that just bury their head in the sand. They say, "Hey, this problem is just too monumental for me, or my family, or my business," and they don't know what to do, they really don't. You know, you get all types of mixed feelings about these things. But I think, somewhere through these discussions, this is one good thing, and let it lead to some kind of unified effort.

I don't know how strong that effort has to be. I don't know if you have to take mandatory testing in every job and everybody before they walk in the door has to, you know, piss in a bottle. I don't know if that's what we have to do.

But I also think that there has got to be some education about the drug, there has got to be an awareness about the drug that we're doing, and then take some action. If a company would hire some counselors to work with *x* amount of people, the money that is going to be spent is going to be well worth it, because look at the money that is being wasted through incompetency on the job force. It's happening in sports; it's happening everywhere.

Mr. **Coats**. Well, you and Mr. Scheu are doing your part, and I appreciate the strong effort that you are making and the message that you are giving to kids.

Thank you, Mr. Chairman.

Chairman MILLER [presiding]. Thank you.

Does any other member of the panel seek recognition?

Mr. Hughes.

Mr. HUGHES. Thank you, Mr. Chairman.

I, too, want to echo the sentiments of my colleagues in congratulating the panel for their contributions. Kevin and Bill, you are doing a good job, and we admire your work, and we appreciate it.

I have a couple of questions of Lee Ann, if I might.

You indicated that you first experimented with drugs when you were 12; you shared a joint.

Ms. LEE ANN BONANNO. Yes.

Mr. HUGHES. Did you smoke cigarettes about that time or prior to that time?

Ms. LEE ANN BONANNO. I started smoking cigarettes at 9.

Mr. HUGHES. At 9 years of age.

Was that the cool thing to do then, to smoke cigarettes?

Ms. LEE ANN BONANNO. Yes.

Mr. HUGHES. How do you feel generally about the pervasive advertising you see on television? Do you think that influences young people like yourself—"Smoke Virginia Slims"—that's cool, too?

Ms. LEE ANN BONANNO. No; that wasn't with me. I did it because everybody else did it.

Mr. HUGHES. Most of the young people that got into smoking joints smoked cigarettes?

Ms. LEE ANN BONANNO. Yes; most of them do.

Mr. HUGHES. How about alcohol? Did you experiment with alcohol some?

Ms. LEE ANN BONANNO. Yes.

Mr. HUGHES. At what age did you begin experimenting with alcohol?

Ms. LEE ANN BONANNO. From when I was small, from tasting beer when I was little. You know, when my mother's and father's backs were turned, I would taste this or taste that, but at, like, 14, when I was hanging out with people, you know, we used to hang around and have beer or have wine.

Mr. HUGHES. Do you feel there was any inducement for you to experiment with other things after you started smoking cigarettes? Did you sort of graduate into——

Ms. LEE ANN BONANNO. The reason why my drug problem graduated is because, when you smoke pot, you feel that gets played out, because then you are going to have to wind up, say, smoking 10 joints to get high, so you go on to another drug. So I wound up going from smoking cigarettes to having a Valium addiction, and from using crack, that I didn't want to stop using crack. I wound up taking more Valium because of crack. I mean it just kept winding up, going up and up the scale. If I didn't stop when I stopped, I'd probably be using heroin, because each high was getting played out, and it was getting more expensive to use that one drug that I would have to go on to something else.

Mr. HUGHES. Were your colleagues, the people that you were hanging around with at the time, also into these same drugs?

Ms. LEE ANN BONANNO. Yes.

Mr. HUGHES. Did your friends get into Valium about the same time you did?

Ms. LEE ANN BONANNO. Yes.

Mr. HUGHES. And they got into cocaine—crack—about the same time you did?

Ms. LEE ANN BONANNO. Yes, sir. A couple of them got into angel dust and have died or committed suicide because of it.

Mr. HUGHES. How much of that was due to the fact that perhaps crack just became available to you?

Ms. LEE ANN BONANNO. Well, crack became available to me about 2 months after I started free basing. You see, crack was always hard to get, because they wouldn't sell it on the street corners like they're selling it now. It would be like in buildings or in apartments. It was like very hush-hush, because before crack was like it is, everybody would cook it up at the house, or the dealer would cook it up and only sell it to certain people, but now it's ridiculous the way crack is being sold; I mean it's all over.

Mr. HUGHES. Now, Lee Ann, you are going into some of the schools and talking to some of the youngsters. What kind of reaction do you get from youngsters? Are they mostly younger than yourself?

Ms. LEE ANN BONANNO. Most of them are younger, but they look, and they say, "I can't look at you and see that you had problems like you had." You know, they don't picture me. I'm a girl, and I'm white, so they figure, "She's not going to get involved with drugs." But most of these kids are black and their families are—you know, most of their families are on welfare, and they can't see that somebody like me got involved like I got involved, but it happens to everybody, I told them.

Mr. HUGHES. What do you think it is that you tell them that impresses them the most?

Ms. LEE ANN BONANNO. I tell them all the bad things that happened to me, all the things I went through.

Mr. HUGHES. Things that happened to you personally.

Ms. LEE ANN BONANNO. Hm-mm, and with people that I used to stay with. Then, in turn, I tell them how I woke up and I saw the light, how I realized I needed help for myself and how my whole life has changed since I got help, and I'm not getting high any more.

Mr. HUGHES. Well, thank you, Lee Ann.

Chairman MILLER. Thank you, and I want to thank all of the members of the panel for your contribution, your time, and your courage to come down and to talk with us. I think it has been very helpful. Thank you very much.

Next the committee will hear from Dr. Jerome Jaffe, who is the director of the Addiction Research Center for the National Institute on Drug Abuse, and David Westrate, who is the Assistant Administrator for Operations for the Drug Enforcement Administration.

Gentlemen, welcome to the committee. We would appreciate it very much—as you can see, a number of members of the committee have questions—you can summarize your testimony, so that we will have time to ask questions, since we are running a little bit behind schedule.

Dr. Jaffe.

TESTIMONY OF JEROME H. JAFFE, M.D., DIRECTOR, ADDICTION RESEARCH CENTER, NATIONAL INSTITUTE ON DRUG ABUSE

Dr. JAFFE. Mr. Chairman and members of the committee, I appreciate the opportunity to testify today at your joint hearing on the growing problem of cocaine abuse. I regret that Dr. Macdonald, who had planned to be here, cannot be here to testify. He is presently at the White House attending a high level meeting to review Federal drug abuse policy.

I will try to summarize my testimony, which has been submitted for the record.

Chairman MILLER. We appreciate that very much.

Dr. JAFFE. I will try to keep my summary to 5 minutes.

The National Institute on Drug Abuse monitors the extent, patterns, and consequences of drug use in several ways. We use household surveys and other epidemiological techniques to gauge the extent, character, and patterns of drug use, and reports of admission to treatment emergency rooms, as well as drug-related deaths as reported by medical examiners to gauge the consequences of drug use.

For almost a decade, we have tracked the cocaine epidemic and its consequences. While it may be that this monitoring system is missing a recent wave of cocaine smoking affecting young people in some minority communities, for the country as a whole we believe the data are reliable. Our formal data systems indicate two trends which at first seem paradoxical. First, after sharp rises in rates of experimentation and use of cocaine beginning in the mid-1970's, there was some leveling off in the extent of use—that is, the number of Americans who have used and are using cocaine. The leveling-off was not a decline; it was a plateauing at the peak levels reached in the early 1980's.

Among young adults aged 18 to 25, 9 percent reported use of cocaine in the past 30 days in 1979, 7 percent reported such use in 1982. The 1985 data from the household survey, which will be available later this summer, will provide an indication as to whether this downward trend has continued, leveled off, or even reversed.

Recent data from a follow-up study of colleage students, a group comparable in age to the 18–25 year olds in the household survey, indicates that use in the past 30 days was about 7 percent for cocaine use in 1985.

Use of cocaine among high school seniors rose significantly from 1984 to 1985, with 13 percent of high school seniors reporting use of cocaine at least once in the year prior to the survey, and 7 percent reporting use at least once in the month prior to the survey.

Despite what appears to be a leveling-off in the number of users, as indicated by the national survey on drug abuse cocaine-related deaths, cocaine-related emergency room visits, and requests for treatment of cocaine dependence have continued to rise to new highs. The DAWN system, which obtains information from emergency rooms in 27 metropolitan areas, indicates that cocaine-related emergency room episodes in these areas tripled from around 3,000 in 1981 to almost 10,000 in 1985. In 25 of these sampling areas, there was a similar tripling in cocaine-related deaths from around 200 in 1981 to about 600 in 1984.

We believe that these findings are not as paradoxical as they may seem. Although our data systems are not seeing any substantial upturn in the number of cocaine users, analysis of these dates do indicate those who are using, cocaine are using more cocaine and using it more frequently. Furthermore, they are using forms of cocaine that are even more hazardous in terms of becoming addicted and in terms of serious toxicity than the intranasal route, which was the most popular route when the epidemic began almost a decade ago.

Foremost among these more hazardous forms is the smoking of cocaine. Cocaine hydrochloride is a salt-like material that is soluble in water but cannot be smoked easily; however this cocaine salt can be converted into a free-base form which readily turns into a vapor when heated. This freebase form can then be inhaled and absorbed rapidly through the lungs. Taken in this way, cocaine gets to the brain more rapidly than when cocaine is injected by the intravenous route. The rapid onset of effect and the very high blood levels produced make this route far more likely to produce both addiction and toxicity. Also the euphoria produced by this route is intense.

Until quite recently, in order to smoke freebase cocaine, users had to purchase substantial quantities of cocaine hydrochloride and then convert it themselves using flammable organic solvents, such as ether. This required special equipment and the money to purchase a significant amount of cocaine, and it involved considerable danger. Despite these dangers and drawbacks, the percentage of cocaine users smoking cocaine appears to have been rising sharply based on data from emergency rooms. For example, in 1983, 2 percent of cocaine-related emergency room episodes involved smoked cocaine. It was 4 percent by 1984. By 1985, that figure had risen to 11 percent of the almost 12,000 total, and in the first quarter of 1986 it was 14 percent. In short, there was a sevenfold increase in the percentage of emergency room episodes involving smoked cocaine. Seventy-eight percent of these cases were in the cities of Miami, Los Angeles, Detroit, and New York.

In 1985, a new way to prepare and market freebase cocaine appeared on the illegal drug scene. This involved preparing freebase with sodium bicarbonate and eliminating the use of organic solvents. This produced a hard, white material, which is now known as "crack" or "rock." Freebase in the form of "crack" has now appeared in many places in the country. The change in marketing that "crack" created has been disastrous in terms of its impact on the extent of use and its consequences.

Instead of selling the cocaine by weight, dealers began selling it in small amounts, one or two doses, enough to smoke once or twice. The price came down to a level where even the young and the nonaffluent could experiment.

These new patterns of use by younger users seem to account for a more rapid onset of dependence, more demand for treatment, and more toxicity. It is quite likely that our survey systems have not yet fully detected the effects of this new form of cocaine and the new marketing system, which in some cities affects the black community disproportionately.

NIDA has been supporting research to understand the mechanisms of the toxic effects of cocaine, including inhaled cocaine, and new methods of treatment. NIDA has also been active in developing prevention campaigns that will bring home to Americans that cocaine is addicting and that cocaine can kill. It is obvious that a special campaign targeted at crack may be needed.

Our more recent publications directed to the professional community are described in the material submitted for the record. Our media campaign on cocaine began airing this spring. Samples of those TV spots are available here for your viewing. New efforts in collaboration with Mr. Ueberroth utilizing non-drug-using athletes are scheduled to begin airing shortly, at around the time of the All Star game.

I'd like to summarize simply by thanking the Chairman for urging the media to get involved in showing these prevention campaign materials.

Thank you, Mr. Chairman. I'd be happy to answer any questions.

[The statement of Dr. Jaffe appears on p. 127.]

Chairman RANGEL. Mr. Chairman, I'd just like to congratulate Dr. Jaffe for the research that he has been doing over the years.

From your testimony this morning, you make it appear as though this is a serious crisis our Nation is facing.

Dr. JAFFE. Yes, I think so.

Chairman RANGEL. Now I know the fine work you are doing with the Advertising Council as well as the Big Lie and other campaigns that you have shared responsibility in. But whom do you share the nature of the crisis with in our Government? Whom do you talk with the same way you have shared this information with us this morning?

Dr. JAFFE. I think that Dr. Macdonald, who is the Administrator of ADAMHA and was recently the Acting Assistant Secretary for Health, has been directly and fully involved in this crisis and has been monitoring the data personally. I am certain that these data are shared directly with Dr. Carlton Turner. In addition Dr. Schuster, who is the Director of the National Institute on Drug Abuse, has shared these data directly with Attorney General Meese on a recent trip they took to explore cocaine and drug trafficking issues.

Therefore, it is my understanding that these data are known by all parties of the Federal Government involved in policy development.

Chairman RANGEL. Wouldn't it be tragic if no one knew but you and Dr. Macdonald?

Dr. JAFFE. It would indeed be tragic, but that is not the case.

Chairman RANGEL. Well, you say it's not the case. Have you had an opportunity to discuss this national crisis at all with the President of the United States?

Dr. JAFFE. I would not expect such an opportunity, no.

Chairman RANGEL. You know, we are talking about something that has been described by former Chief Justice Warren Burger as, in his opinion, a more serious threat to our national security than communism. We're talking about a situation where the President of the United States, and the Commander in Chief, has indicated that it is a national security problem.

So I don't want you to be shy, Doctor, about the Presidency, because you have more information than probably Caspar Weinberger has or Secretary Shultz or whoever. So if you're just giving it to Dr. Macdonald—how about Secretary Bennett? Have you shared it with Secretary Bennett?

Dr. **Jaffe**. I have not done so personally. I'm sure he is aware of this.

I might point out, Mr. Chairman, that at this moment there is a Cabinet meeting on drug abuse, and, to the best of my understanding, Secretary Bennett is at that Cabinet meeting.

Chairman **Rangel**. You don't know how moved I am by hearing that.

Dr. **Jaffe**. They are discussing drug abuse policy at levels that I think you would approve of. They do see it as that level of seriousness.

Chairman **Rangel**. I just can't restrain myself to believe that the Secretary of Education is involved in a Cabinet meeting at this moment, discussing the drug epidemic. I tell you that it just shows what can happen when you are patient.

But in any event, I will be distributing your testimony to Secretary Bennett and to other people, and I hope that you might find some way to support this committee's effort in calling for a White House conference, because you have given support to our greatest fears that not only do we have a problem but we have a growing problem, and I hate to be facetious with the quality of testimony that you have given, but if you can't share it with the person responsible for educating the Nation, if you can't share it with the people responsible for our foreign policy, where this stuff is coming from, if you can't share it with those that are making decisions as to how serious it is, then we will distribute it and perhaps send it, return receipt requested.

But the committee is satisfied that you are doing a great job. We only wish there were some way that we could let other people know how serious the problem is.

Thank you for your testimony.

Chairman **Miller**. Mr. Westrate.

TESTIMONY OF DAVID L. WESTRATE, ASSISTANT ADMINISTRATOR FOR OPERATIONS, DRUG ENFORCEMENT ADMINISTRATION, U.S. DEPARTMENT OF JUSTICE

Mr. **Westrate**. Chairman Miller, Chairman Rangel, I would like to add that the Drug Policy Board this afternoon is meeting at the Cabinet level, and the issue of crack cocaine is on the agenda. In fact, I will be providing them a briefing as well, and this is not the first time that this issue has been discussed by the policy board.

Chairman **Rangel**. Could you share with me who will be involved at this meeting? because it could mean that more is being done than we know. You said that crack has been on a Cabinet agenda before this morning?

Mr. **Westrate**. Yes, sir.

Mr. Chairman, the Drug Policy Board, of course, is a board that is composed of Cabinet-level officers, and this afternoon either they, personally, or their senior representatives will be present, I am sure.

Chairman RANGEL. OK, but you're not able at this time to share with me what actual Cabinet members have discussed the question of crack with this Drug Policy Board prior to this morning?

Mr. WESTRATE. No, but certainly after the meeting we will, and I'm sure that their staff will report to them the contents of the board deliberations.

Chairman RANGEL. Oh, I'm certain that we will be able to find that out. But you said that this is not the first time it has been discussed, and I just wondered whether you would share with me what Cabinet members, as opposed to their designees, have discussed the question of drug policy, with or without crack being on the agenda.

Mr. WESTRATE. I'm sure that can be accomplished after the meeting.

Chairman RANGEL. I guess my question is not as clear as I would want it, but you had indicated that there had been prior meetings, other than the one being held this morning, of Cabinet members discussing this subject, and in my way I was challenging that by asking you what Cabinet members and at what time.

Mr. WESTRATE. Well, I haven't personally attended those previous meetings, but I'm sure the minutes of those meetings are available and the attendees listed.

Chairman RANGEL. How would I be able to get a copy of those minutes?

Mr. WESTRATE. Through the Drug Policy Board.

Chairman RANGEL. Whom do you know that serves on there that you could request it from for the committee?

Mr. WESTRATE. I would suggest that you make a request of the Attorney General's Office.

Chairman RANGEL. Thank you.

Mr. WESTRATE. OK. Thank you.

I, too, will summarize my statement—it has been presented—and limit my remarks to about 5 minutes.

Cocaine hydrochloride, available on the street at 30 to 40 percent purity, remains the most common coca product in the United States. The predominant methods of cocaine abuse continue to be primarily through inhaling and, to some extent, injecting cocaine hydrochloride. In the past year or so, however, the use of crack has become increasingly prevalent in certain areas.

Crack has an off-white color, resembling coagulated soap powder or pieces of soap. Crack made either with baking soda or ammonia is smoked in a water pipe or sprinkled over tobacco or marijuana cigarettes and smoked. The word "crack" either comes from its crackling sound when it is smoked before it has dried or from occasional resemblance to cracked paint chips or cracked plaster. It is sold on the streets usually in small vials, glassine envelopes, or sealed plastic bags, at purity levels between 60 and 90 percent.

Although amounts vary, small vials contain an average of 100 milligrams of crack, which cost approximately $10. Preliminary information indicates that nationwide 250 milligrams costs $25 and

500 milligrams costs between $40 and $50. A $10 vial of 100 milligrams can provide one, two, or three inhalations when smoked in a pipe, depending on how deeply the user breathes.

Crack is sold on the street or in crack houses, also known as rock, base, free base, or smoke houses. The definition of what constitutes a crack house varies from city to city. In some cities, a user can both purchase and smoke the drug on the premises. In others, a user can only purchase the drug and is not allowed entry. Still in others, a user must bring his own crack because the drug is not sold on the premises; the house simply provides a room and a pipe for smoking crack.

The euphoric effect produced by smoking crack is far more intense than if the cocaine is ingested through inhaling and at least equal to, if not surpassing, that obtained through injection. Crack's effects occur rapidly, generally in a few seconds, and usually last from 5 to 10 minutes. Following this a user may experience a restless irritability accompanied by severe depression and an almost insatiable craving for more of the drug.

Crack has emerged as a major drug problem in less than a year. As a result, data on usage, emergency room mentions, and arrests have not focused on crack as an individual category of drug abuse apart from cocaine.

The 800-COCAINE hotline has gathered some statistics on crack abuse that show preliminary trends among users. They conducted a random sample of 458 primary cocaine users who called the hotline during May 1986. Of these 458 persons, 144, or 33 percent, were using crack. They spent over $100 per week on the drug on the average. The vast majority, 81 percent, said they had switched from snorting occasionally to smoking crack.

These hotline statistics from May 1986 also indicate that 82 percent of the callers using crack reported a compulsion to use the drug again as soon as the brief high had worn off; 78 percent reported the onset of compulsive use and significant drug-related problems within 2 months of their first use.

DEA, last week began an extensive indepth intelligence survey through all of its domestic field offices to try to discern the use and availability of crack, its purity, and its price. Local drug treatment professionals and police departments nationwide are being contacted for this study, and we will use the results of the study to help define our strategy for dealing with the crack problem.

To begin our formal inquiry into the extent of the crack situation, DEA held a conference on crack this past June in New York City. Participants included DEA officials, law enforcement officers, health and medical experts, and representatives of the National Institute on Drug Abuse.

Progress against the crack problem is tied directly to our ability to impact on the original cocaine source and major trafficking, smuggling, and distribution organizations. This is the area where we will continue to place the majority of our efforts. Efforts in local areas will be taken in cooperation with local police or established task force programs.

In the international arena, DEA coordinates or participates in a range of enforcement and cooperative efforts to control cocaine production and distribution from South America. For several years, DEA has spearheaded Operation Chem Con, which stands for chemical control, to reduce the availability of essential chemicals used in the illicit manufacture of cocaine hydrochloride and other drugs.

In 1985, approximately 2,600 55-gallon drums of ether were seized in the United States and abroad. This amount of ether would have produced more than 30,000 kilos of cocaine hydrochloride worth nearly $1 billion.

Operation Stop Prop is another joint operation that started and mainly operates in Latin America but which is expanding into the Caribbean. Its goal is to minimize general aviation smuggling of cocaine using a sophisticated intelligence program to find clandestine laboratories and airstrips and the aircraft used by these traffickers.

One of the most important developments in recent years is the success of the International Drug Enforcement Conference, also known as IDEC, which was initiated by DEA in 1983 to foster cooperation with South American and Central American governments by creating a network of law enforcement executives with the unified goal of eradicating drug trafficking. At the fourth annual meeting in April, resolutions were passed to work on multilateral extradition treaties, the enactment of more uniform penalties for narcotic crimes, to adopt a goal of Operation Stop Prop, and furtherance of regional narcotic enforcement programs.

In combination with enforcement strategies to deal with crack, DEA is also approaching the problem through its demand reduction emphasis on prevention and education. DEA now includes a presentation on crack in each of the DEA-sponsored sports drug awareness program seminars for high school coaches. These coaches, in turn, can help reach 5.5 million student athletes who may act as role models using positive peer pressure to keep their students from using drugs.

We have also at DEA created a demand reduction section, including agents and other demand reduction specialists. DEA's continued area of emphasis is to reduce the flow of all cocaine into the United States. The different aspects of the national strategy to address the cocaine problem which also encompasses crop eradication and other cooperative efforts in the international sphere, investigations and prosecutions of the upper level of cocaine trafficking, and of course demand reduction will ultimately have the desired effect on the crack problem as well, we hope.

Mr. Chairman, we appreciate the committee's interest in this fast-growing problem of crack. We, too, consider it to be extremely serious, and hope that this hearing will help to bring this to the attention of the American public and to policymakers throughout the country and internationally.

I have brought for your inspection, if you are interested, some of the paraphernalia and street packaging types of things that we are seeing, particularly in the New York area.

Thank you.

[The statement of Mr. Westrate appears on p. 144.]

Chairman Rangel. Mr. Chairman, I would just like to make an inquiry here.

First, I would like to congratulate the Drug Enforcement Administration for the great job they are doing in terms of getting more international cooperation in working closely with the State Department.

Having said that, since we are dealing with crack, which is a derivative of cocaine, based on intelligence that you have been able to pull together, Mr. Westrate, what would you think the projections are in terms of the amount of cocaine that we should expect to have coming into this country this year? And compare it perhaps to last year.

Mr. WESTRATE. Well, I would not expect to see a major change in the flow this year. I think the key to this is the level of demand.

Crack, of course, should not be confused as a new drug; crack is really a new form of using cocaine. So the key to solving the crack problem from the source of supply aspects is identical to the strategy that is necessary to solve the cocaine problem in general.

Now if crack becomes much more widely used, as we all fear, and therefore the demand increases, theoretically the traffickers in South America would respond to that demand with further production, but to increase production in cocaine is not a short-term thing, of course; you have to grow the cocabush, which takes some time to do.

Chairman RANGEL. But what you are saying is that we should expect the same amount, if not more, cocaine coming into the United States.

Mr. WESTRATE. Yes, minus what we are able to interdict and eradicate; yes, sir.

Chairman RANGEL. Well, including what you are able to interdict and eradicate. I'm saying, isn't it safe to say that we should expect just as much, if not more, cocaine and therefore crack into the United States no matter what you are able to interdict and eradicate?

Mr. WESTRATE. Unless there are major changes in factors such as demand and/or crop eradication.

Chairman RANGEL. You know, I'm having difficulty because what I try to do at these hearings is to have one part to deal with law enforcement, another part to deal with international affairs and how we are going to deal with these nations, and then the other part to deal with education. But it seems that the more I deal with law enforcement, the more they are telling me that it's an educational problem and that in order for them to be effective we are going to have to reduce demand.

Mr. WESTRATE. Mr. Chairman, we certainly wouldn't want to substitute one area or strategy for another. I think law enforcement recognizes——

Chairman RANGEL. I don't mind this happening to me, that law enforcement would tell me that it's a demand reduction problem and that education is so necessary. But you have to admit that it is frustrating when I then go to the Secretary of Education and he tells me it's a law enforcement problem. You can understand that.

Mr. WESTRATE. We view it as a multifaceted problem in which the Government and the Congress and the people have to make a concerted effort on all of the major elements. I don't think the strategy can be focused on one area.

Chairman RANGEL. The DEA is doing one heck of a job in education and demand reduction, and you have exposed yourself to 5.5

million people to educate them. Would it be embarrassing if I asked how many people do you think the Secretary of Education has exposed his agency and department to in terms of demand reduction?

Mr. **Westrate.** 1 couldn't answer that question. I don't have those facts.

Chairman **Rangel.** Well, I could ask him how many people has he advocated kicking out of school and having arrested, but that wouldn't be fair to ask him that, because he's in education.

In any event, it seems to me that somebody has to get together and share this information. If the Secretary of Education is not listening to Dr. Jaffe and you and the Drug Enforcement Administration, the FBI, the assistant U.S. attorneys, the New York City Police Department, they're in our local schools educating the kids as to abuse, then we're not doing something right here in Washington.

So we hope you continue to do whatever time allows for you in law enforcement but continue to do the great job you are doing in education and demand reduction.

But no matter how we take a look at your testimony, we believe here in the Congress that eradication and reduction in production is something that we should not look forward to in the next 5, 6, 7 years, and so we are going to have to depend on what you can interdict and have to depend on how many people you can educate.

But if you hear what the Drug Enforcement Administrator has said to Secretary Bennett at this higher meeting that is being held, share it with us.

Mr. **Westrate.** I would be happy to.

Chairman **Rangel.** Thank you.

Chairman **Miller.** Mr. Westrate, in response to Chairman Rangel's question, you indicated that you see no change in the current situation in terms of the amount of cocaine in the country. You said unless we see a major shift in demand and/or eradication, you would see no change in the amount of the cocaine coming into the country?

Mr. **Westrate.** Well, I don't see any dramatic change in the next year—let's say in the short term. It depends a lot upon the success of our interdiction programs. We were very successful last year in seizing 50,000 pounds of cocaine.

Chairman **Miller.** I understand that. I am not quarreling with that. I am just trying to quantify the situation, and if you see no dramatic change, then for us as policymakers, I assume that we would anticipate the figures that are developed by NIDA and others would be repeated in the coming year.

Mr. **Westrate.** Yes; I don't see a dramatic reduction in supply unless we are able to make very quick progress in the coming year in eradication overseas or in interdiction, but I don't see a dramatic change.

Chairman **Miller.** Let me ask you if crack doesn't present sort of a new marketing opportunity to those people who would peddle drugs. We argue very often that it is a demand-related business, and yet what we really see is a conscious effort to expand the market even if the same amount of cocaine is being consumed, because the manner in which the marketing is being done makes it far less expensive for those who might use it, so they are more able to. Isn't that happening?

Mr. WESTRATE. Well, I think there are two aspects to consider here. First of all, yes, a marketing technique and something that is different, and the important aspect of that is the small amounts that are sold for a fairly small amount of money—$10, $5. That is very important.

Chairman MILLER. So that is broadening the potential market; is it not?

Mr. WESTRATE. Yes; the potential customers.

The other aspects, and one that is probably more important, are the more serious health consequences of utilizing cocaine by smoking, and those are very, very serious in terms of, first of all, potential impacts upon the body as the cocaine is being used in terms of heart attacks and other kinds of things. The second part of that is the abuse potential in terms of dependency, and what we are being told is that by smoking cocaine, the dependency that a person develops, develops much more quickly and much more seriously, and therefore that might have an impact on how much cocaine is actually being used per person.

Chairman MILLER. Dr. Jaffe, let me ask you something. I am told that at the end of these public service spots there is an 800 number put up for people to call. The staff of the select committee made an attempt to reach that 800 number, I think they tried 9 or 10 times, and 7 of those times it was busy. The 3 times it was not busy they got a recording that told them to call back between 9 and 5 Monday through Friday, which were the exact hours in which they were calling.

Then they were told to call a 911 number if, in fact, it was an emergency. I read in this morning's paper that for the first time, I think, now in the District of Columbia, you do not get a recording dialing 911. If you call 911, you now have some opportunity of getting a human being on the other end of the line. I am a little concerned about the effectiveness of this number if in fact we have people responding to very good spots, and then getting a recording. I think what we see from the cocaine hot line, the private hot line, that we get people who are calling in desperate situations, people who for the first time have tried to reach out for help, and that's not apparently available through this hot line.

Can you comment on that?

Dr. JAFFE. I can comment to some degree. Perhaps Susan Lachter, who is here, can comment more fully.

This line was established within NIDA's current budget as an answer to our perception of an immediate need even though there were private groups operating such hot lines. Nobody at NIDA is paid to work in the evenings, and for some months we have had volunteers at NIDA working extra hours.

They are now expanding the number of WATS lines, to meet the increased demand. The fact that the lines were busy suggests that the hotline is needed and is being fully utilized.

Chairman MILLER. Well, the fact that the line was busy, if that was the only problem, would be encouraging because it would indicate people are reaching out who may have themselves, or a family member become involved. But when the line isn't busy, the fact that you get a recording telling you to call back in the exact hours in which you are calling, or you are referred to 911 which in many jurisdictions is in itself a recording—that's not your problem—is disturbing.

Dr. **Jaffe**. Yes.

Chairman **Miller**. Because there is at least evidence from the private hot lines that it is a very effective tool in terms of getting those people to reach out for some kind of help, and I am not casting dispersions on what you are trying to do. You know, you started your explanation with exactly what I think illustrates the problem that we are seeing in these two committees. That is, within the constraints of this budget, we never have enough money to do our programs on a first-class basis. We are always trying to do it on the cheap, and on the cheap doesn't work, and we are not being able to respond to a very vulnerable population.

Dr. **Jaffe**. I think the original thought was Federal Government should not compete with the private sector.

Chairman **Miller**. Dr. Jaffe, let me tell you something. Since this administration has come to town, they have said the same thing, and do you know what the private sector has always said? Never once have they suggested—people who have spent their life, spent their money, spent their fortunes to help young people in this country, never have they suggested that the Government has been competing with them.

What, in fact, all of the foundations have told us, what the corporations have told us, is that Federal money was there for the purposes of leveraging the private sector. They never felt crowded out, and what they are seeing now is a diminution of services because the Federal Government has retreated. So let's not start with that poppycock that somehow this can all be handled on a volunteer basis. You talk to the volunteer agencies. They help you compile the statistics of death and destruction, and what do they tell you?

None of them can meet their case load. None of them can meet it on a current basis. We just had a testimony from a mother and daughter here who told us about a very successful program. It has just had its funding cut 50 percent, so let's not talk about competition. I hope we come to the day when we are worried about competing for the victims of drug abuse, and we are competing with the efforts to stop the inflow into this country. That competition is nonexistent in this country because what we do have is a few sporadic efforts by well-intended people with no support from their Government, whether it is for education or eradication or anything else that we say is necessary for this effort.

Dr. **Jaffe**. Is that a question, sir?

Chairman **Miller**. No; that wasn't a question. It was to put to rest this business that this administration has told us that there is competition to take care of the homeless; that there is competition to take care of the retarded; that there is competition to take care of the poor. There isn't. That's why they are lined up around the street. If there was competition, we would be out looking for them. They are looking for us.

Dr. **Jaffe**. Are you interested in something about the hotline?

Chairman **Miller**. Yes; I am very interested.

Dr. **Jaffe**. Fine. Susan.

Ms. LACHTER. I'm not exactly sure why you would have gotten——

Chairman MILLER. I want to know why you get a busy number when you call the hotline, and when you don't get a busy number you are given a recording that tells you to call back between 9 and 5 on Monday and Friday and you are calling between 9 and 5 on Monday and Friday. For people who are on drugs, maybe that sounds normal, but for the rest of us it doesn't.

Ms. LACHTER. As a person that staffs the hotline during those hours, I can't answer why two times out of nine you received that message. I do know why the lines are busy. They are busy from morning until night. We never expected the kind of response we have received. We never expected that half the people that call would be users. We didn't expect we would be able to get to users—that they really would pick up a telephone and call to find a location where they could get help.

Chairman MILLER. Apparently there is not enough competition so that we can ferret them out.

Ms. LACHTER. Well, I think we are talking to the people out there that really want help.—I am so glad that Congressman Rangel has been helping to push the campaign. There is something in those spots that says to users, "Don't tell us more denial. I am the same as you are. I have had those feelings. I have gone through that pain, and I need help." I think that is the most gratifying part of the hotline.

Our staff has volunteered in the evenings when they can. During the day we will be able to expand the number of lines and the number of responses. There are thousands of people that need help and we are trying our best to get to them.

About half the calls are from family members and others. Mostly they want to say, "How can I get my loved one to realize they need help?" I think one of the things we hope to do in an educational way is say, "Hey, you really need the help. Listen, nobody else can get the help for you." Everybody calls and says, "How can I get my loved one into treatment?" Just like the mother and daughter who just testified, you know there is a problem, but unless the person wants the help, they won't come and get it. We are doing our best to reach people in need of help.

With regard to the 911 issue, I don't know what to tell you. Our issue is——

Chairman MILLER. That's not your responsibility. I understand that.

Ms. LACHTER. No, but the issue is going back to the local community for help. The means of our hotline is to direct the caller to the local community for help. When we hear someone in trouble, we tell them call 0, call 911, get yourself help right away. Get to an emergency room. That's the only way. We can't get medical treatment to that person, and yet we know when they need it they have got to get it immediately. So we are just hopeful that what we can do is really touch people out there. We realize they are reaching out, and that is good.

Chairman MILLER. I don't quarrel—I think you are in the right direction. We have seen these kinds of public service spots. You know, with spousal abuse you put the number on the screen and the phones ring right off the hook, and I think that is the right direction to go, especially if you tell me half the people are users as we are finding out in the other line. It is just that I want it to be effective.

If you are startled by this response, I hope that other people in the administration are startled by the response. I used to work on a hot line for suicide prevention in a mental health clinic, and there is a joke about putting people who want to commit suicide on hold. You know, you can't deal with this kind of vulnerable population by putting them on hold or giving them a recording, and if what we need are the financial resources so that humans can be there to accept these people when they show the courage to reach out, then that is what we have got to fight for, and we can't pretend like that is not what is necessary and that somebody else is going to take care of it, because all of the evidence is that it is not.

All of the evidence is that every one of these systems, whether they are provided by the churches or the foundations or any other organization, are absolutely stretched to the maximum, and at some point we have got to quit talking about this phony notion of competition and start talking about how we really augment what a lot of decent people are trying to do in each and every one of our communities, and how we can leverage that into more voluntarism and more efforts and more full-time bases, because, you know, somebody's future with relation to drugs should not be based upon whether or not a volunteer was able to come in or not come in.

It sounds to me like we have a full-time problem that needs a full-time solution. I am sorry for taking more than my allotted time.

Chairman RANGEL. Would the gentleman yield?

Chairman MILLER. Yes.

Chairman RANGEL. I just have one question. Suppose the person does get through. What advice would you give that person? In New York City I have been advised by Julio Martinez that he has an overcrowding; that he has a long waiting list and that he cannot take care of the oldtime addicts, much less develop a modality for the crack addicts. So assuming that they got through, what would they hear?

Ms. LACHTER. Well, we have a list, as you know, of all the treatment programs in New York. We have also read the reports from Mr. Martinez. Some programs in New York, such as Phoenix House, have established outpatient services treatment and have done interim measures and attempts to try to deal with some of the people that they normally take in residential programs. We understand that several other programs are trying to do this.

We don't have a magical solution, but we are trying to get people to at least talk to treatment people and find out where the openings are and where they can get some help.

Mr. GILMAN. Thank you, Mr. Chairman. I would like to address both Dr. Jaffe and to Mr. Westrate, there is no question that we are confronted with an epidemic of crack in our country. You don't have any question about that premise, do you?

Dr. JAFFE. I think that crack is on the increase, yes.

Mr. GILMAN. And, Mr. Westrate, your information?

Mr. WESTRATE. We consider it very serious. Obviously in New York it is at a very high level, and we are seeing a constant spread across the country.

Mr. GILMAN. And we don't have any accurate information with regards to how extensive the problem is; is that correct?

Mr. WESTRATE. Well, in law enforcement we don't yet, although we are changing our systems. Within DEA, for example, we are putting a new indicator in to show us the difference between a regular cocaine hydrochloride case and a crack case so that we can begin to get a handle on it.

Mr. GILMAN. You are both pretty much expert. What would you estimate to be the extensiveness of all cocaine abuse in our country? How many people are involved in cocaine abuse including crack? Would you give us an estimate of what you feel is the amount of usage in this country at this time? How many people are involved would you say? Dr. Jaffe, Mr. Westrate, you both are experts. You have all of the informational channels available to you. What would you estimate to be the extensiveness of the problem?

I'm sure you have been confronted with that question many times.

Dr. JAFFE. I think it is important to frame it in terms of the extent of use. Use can be anywhere from once a year——

Mr. GILMAN. Well, let's say cocaine abuses. Let's start there.

Dr. JAFFE. If you are talking about use within the last 30 days, our data suggest that 7 percent of high school seniors are using the drug. One can multiply that by the number of people in that age group, and it is a matter of millions using cocaine at that rate.

Mr. GILMAN. Mr. Westrate, do you have any comment on that?

Mr. WESTRATE. The numbers we usually refer to are 4 to 5 million regular users and 20 to 22 million total people who have tried cocaine at some point in time.

Mr. GILMAN. Any idea of the number of users of crack in the young age group of up to age 13 or 14?

Mr. WESTRATE. No, but I will say this, that in my more lengthy statement we gave some figures from the cocaine hotline that indicated that most of the users were not at the very low age group, at least those who are calling the hot line.

That has to be, of course, clarified. They are only able to collect information from those who call.

Mr. GILMAN. Do you agree with that, Dr. Jaffe, that most of them are in the higher age level?

Dr. JAFFE. Those who call, yes. No question.

Mr. GILMAN. What about the other information that you have available? We are hearing from our communities that some of the very young are involved in abusing crack.

Dr. JAFFE. We hear the same reports. The difficulty, as Mr. Westrate pointed out, is that crack appeared within a year. We have categorized cocaine use as to injected, snorted, smoked, but we hadn't made the distinction in our surveys between freebase prepared in the more elaborate way, which has been around for several years, and crack, so it is very hard to tell about actual crack use.

Mr. GILMAN. You have no idea, then, today of how extensive the use is amongst our schoolchildren; is that correct?

Dr. **Jaffe**. I would not say we have no idea at all. We do have data from the household survey that samples young people above the age of 12. That data will be made available shortly.

Mr. **Gilman**. Roughly, what percentage are you finding?

Dr. **Jaffe**. It was a very low percentage the last time we had the data.

Mr. **Gilman**. How old is that data?

Dr. **Jaffe**. The data that we have available on people above the age of 12, I believe, is 1982 data.

Mr. **Gilman**. What date?

Dr. **Jaffe**. 1982.

Mr. **Gilman**. Well, of course, you are telling us that crack is just beginning to spread across the country like wild fire in the last year. We have no current data; is that correct?

Dr. **Jaffe**. I think it would be fair to say that we do not have any accurate estimate at this time.

Mr. **Gilman**. Are we trying to update our data somehow so that we know how extensive the problem is?

Dr. **Jaffe**. There have been meetings of a group called—the Community Epidemiology work group—where people who are doing local surveys meet twice a year.

Mr. **Gilman**. Well, is your office or is the DEA office asking for better intelligence on the extensiveness of it?

Dr. **Jaffe**. NIDA does do that. We have some figures that are estimates at this point.

Mr. **Gilman**. I am asking you whether you have undertaken any initiative to try to determine how extensive the problem is. Is either DEA or NIDA undertaking any current initiative to try to get an accurate estimate of how extensive the problem is?

Dr. **Jaffe**. I may be able to give you that answer in a moment if you let me turn around.

The head of our epidemiological unit is here and he can report on what steps have been taken.

Mr. **Gilman**. Well, can he step up and tell us whether or not we are trying to determine just how serious the problem is?

Dr. **Jaffe**. He can tell you what has been done in the last 3 months.

Mr. **Gilman**. While he is coming to the table, do either of you ever get involved in any of the policy decisions on what we are going to be doing about crack, for example? Have you been called in and said, "Hey, we have got a serious problem. What are we going to do about it?"

Dr. **Jaffe**. Yes, I have been involved in some of them.

Mr. **Gilman**. With what policy group?

Dr. **Jaffe**. At the level of NIDA and at the ADAMHA level with Dr. Macdonald.

Mr. **Gilman**. Beyond that?

Dr. **Jaffe**. Not since March.

Mr. **Gilman**. Has Dr. Macdonald been involved in any policies?

Dr. **Jaffe**. Yes, he has.

Mr. **Gilman**. Where?

Dr. **Jaffe**. At the White House level. He is briefing the White House today on the crack situation to the best of my knowledge.

Mr. **Gilman**. Today?

Dr. JAFFE. Today.

Mr. GILMAN. Prior to today has he been involved in any policy on crack?

Dr. JAFFE. To the best of my knowledge, he meets regularly with Dr. Carlton Turner. I know that Dr. Schuster, as recently as 2 months ago, spent quite some time with Attorney General Meese, and crack use, I'm sure, was one of the issues on the agenda, because they were primarily concerned about cocaine abuse.

Chairman. RANGEL. Would the gentleman yield?

Mr. GILMAN. Yes.

Chairman RANGEL. Why are you doing this to yourself, Doctor? You say that Dr. Macdonald talks with Carlton Turner.

Dr. JAFFE. Yes.

Chairman RANGEL. You think.

Dr. JAFFE. No.

Chairman RANGEL. Who does Carlton Turner talk with?

Dr. JAFFE. I don't know.

Chairman RANGEL. So what are we talking about? You are the guy that knows, so you talk with Dr. Macdonald. He talks with Dr. Turner. Dr. Turner talks with nobody.

Dr. JAFFE. I can't answer other than——

Chairman RANGEL. I know you can't, but you are trying so hard to say that—you are making assumptions that really you shouldn't make because there is nothing we would want to believe more than the fact that your information and Dr. Macdonald's information is going to the Secretary of Education and going to Secretary Shultz and going to Carlton Turner who in turn will give it to the President. None of this is——

Dr. JAFFE. I am certain it goes to Dr. Turner because reports are sent up on these issues on a regular basis. I can't testify beyond that.

Chairman RANGEL. But you don't have any evidence that Dr. Turner meets with the President at all. None. We don't either.

Dr. JAFFE. I have no knowledge of Dr. Turner's schedule. That's correct.

Chairman RANGEL. OK.

Mr. GILMAN. Mr. Westrate, have you been involved in any policy meetings with regard to crack?

Mr. WESTRATE. Yes; I am involved on a regular basis. As I mentioned in my testimony, we had a crack conference in New York which was designed especially to help DEA develop its policy. We had health and law enforcement personnel there in June. We also have started our survey of the entire United States utilizing DEA facilities to confer with law enforcement and other professionals on this particular issue. We are very concerned about it. We believe also it has a tremendous potential amongst the younger user areas, and we are dealing on a regular basis, a daily basis, with the Drug Policy Board.

I confer with Mr. Charles Blau of the Department of Justice on a regular basis. I have conferred with Dr. Turner as recently as this past Thursday or Friday on this very issue. He and I have had conversations about the concern of the President, and I can tell you that this issue is a major, major concern of the Drug Policy Board.

Chairman RANGEL. Would the gentleman yield on that?

Am I to imply that Dr. Turner shared with you a meeting he had with the President of the United States?

Mr. **Westrate**. He has discussed the senior staff of the President——

Chairman **Rangel**. Please, help me out, Mr. Westrate. I am just trying to say that in the course of your testimony, do I get from that that when you talked with Carlton Turner that he had said that he talked with the President?

Mr. **Westrate**. I was not present at those meetings, but I can tell you this: That we discussed potential initiatives that he had discussed with senior——

Chairman **Rangel**. I am going to try my question again, because I probably have an impediment in expressing it. You said that you finished just last week in talking with Dr. Carlton Turner. Right?

Mr. **Westrate**. That's correct, sir.

Chairman **Rangel**. Now, in the course of the conversation that you had with him and he had with you, did Dr. Turner say at any time that he had a conversation with President Ronald Reagan?

Mr. **Westrate**. Well, I will say this: He specifically said that the issue was discussed with senior White House staff and it is my assumption—I cannot say that he said it specifically. It is my assumption that the President is aware of things that are being developed and potential strategies, and I would be quite surprised if he was not.

Mr. **Gilman**. Would both the panelists, Dr. Jaffe and Mr. Westrate, respond to my inquiry that since this crack problem has become so pervasive in the last year, have there been any new initiatives by either NIDA or DEA in our strategy and our policy in how to attack the problem?

I know that NIDA is going to have an August meeting, Sharing Knowledge for Action. I commend you for that kind of a meeting. Incidentally, where and when will that be held, Dr. Jaffe?

Dr. **Jaffe**. I can get that for you, Mr. Gilman.

Mr. **Gilman**. I would welcome it if you could notify our committee.

Dr. **Jaffe**. Crystal City.

Mr. **Gilman**. What's the date?

Dr. **Jaffe**. The first week in August.

Mr. **Gilman**. All week long?

Ms. **Lachter**. I believe it is a 4-day meeting.

Mr. **Gilman**. A 4-day meeting the first week in August at Crystal City, and hosted by NIDA?

Ms. **Lachter**. Hosted by NIDA, yes.

Mr. **Gilman**. Sharing Knowledge for Action.

Now, besides that kind of initiative, have there been any other initiatives by either NIDA or DEA that are specifically designed to focus in on crack?

Mr. **Westrate**. Yes, we are doing a number of things in DEA. First of all, we are producing intelligence so that the law enforcement community and others are aware of what crack means and all the aspects associated with it. In New York, where we have the most serious problem at the moment with crack, we are working very closely with the New York City Police Department. They have formed a task force, as I am sure you will hear from later witnesses.

We have formed a special crack group within our traditional DEA/New York City/New York State Policy Task Force to focus particularly on crack activities and in particular any potential conspiracy or higher level activities relative to organizations that are on top of the crack problem.

Again, it is a very difficult problem for law enforcement because the crack trafficking, although it is a major health concern and it is spreading, it is not really at a level where we have traditionally been focusing our Federal and/or State local task force resources. So we are having to make some adjustments which we will do in terms of attempting to have an impact on this very serious problem. These are a number of initiatives underway.

Mr. GILMAN. It has grown serious enough now so that you can devote some special activity to it.

Mr. WESTRATE. Absolutely.

Mr. GILMAN. Thank you.

Now, would you please identify yourself?

Mr. ADAMS. My name is Edgar Adams. I am the Director of the Division of Epidemiology and Statistical Analysis at NIDA.

Mr. GILMAN. Can you tell us is there any sound information or any study that we have undertaken of the extensiveness of the use of crack or the abuse of crack in our country?

Mr. ADAMS. It has already been mentioned that we have the Community Epidemiology Work Group, which has representatives from approximately 20 cities. This group meets twice a year to discuss new and emerging trends.

Mr. GILMAN. Is that part of NIDA?

Mr. ADAMS. It is sponsored by NIDA, and one of the people who will be speaking here today, Mr. John French from New Jersey, is a member of that group. It consists of experts from 20 major cities throughout the country.

Mr. GILMAN. Have you undertaken a study of the extensiveness of the abuse of crack?

Mr. ADAMS. Not of the prevalence of crack. We do sponsor the high school senior survey, and Dr. Johnston did add questions on crack which were asked this spring. We expect to have that data available by November.

Mr. GILMAN. Has there been any summary analysis of that data at this point?

Mr. ADAMS. It is not available yet. The State of New Jersey using an instrument developed by NIDA for its 1985 national survey added questions on crack. That survey, I believe, went into the field this month, and perhaps Mr. French can address the specifics of their effort.

Mr. GILMAN. How extensive is your survey? Does it reach every school?

Mr. ADAMS. It is a nationally representative sample of 130 schools throughout the United States. It covers approximately 16,000 students.

Mr. GILMAN. From your knowledge of the survey and the basic information that you have received already, can you estimate for us how extensive the abuse of crack is in our country?

Mr. **Adams**. The most recent data that we have is from 1985, and what that data indicated was that the current use of cocaine in all forms, that is, any use in the last 30 days, has increased over the past 2 years. Now it stands at approximately 7 percent of high school seniors reporting that they had used cocaine in the past 30 days.

The household survey which was also conducted in 1985 contains people from the age of 12 to 17 as well as those 18 and above, and we will get a better estimate of the use of cocaine in younger age groups. In addition, questions were asked on route of administration so that we will be able to make an estimate on the number of people who have ever freebased cocaine.

In relation to crack I would just like to point out that it is a drug phenomenon which has occurred within the last year, and it is very difficult to mount major surveys to address problems like that. However, we do have two initiatives that we are investigating. One is the use of opinion polls, and as part of an experiment we did put questions in the Gallup poll on the use of cocaine.

In the future, if the experiment works out, we will be able to go in very quickly, within 6 weeks or 2 months, and reassure prevalence levels of new drug trends. We are also working with the National Center for Health Statistics on what they call a rapid survey response technique where we would use telephone surveys. Again, if there are emerging problems in a variety of areas, we would be able to use these techniques.

Mr. **Gilman**. Am I correct, then, that at this point we really don't have any definitive knowledge of how extensive the use of crack is in our country with all of our expertise; is that right?

Mr. **Adams**. That's correct.

Mr. **Gilman**. Is that right, Dr. Jaffe?

Dr. **Jaffe**. That's fair.

Mr. **Gilman**. Mr. Westrate?

Mr. **Westrate**. Yes, I would say especially with statistically valid information.

Mr. **Gilman**. Well, I hope that we find a way of determining how serious the problem is, because we are hearing it from every direction—from our people in education, law enforcement, our local officials, and here we are at the Federal level and we have no idea of how extensive the problem is, let alone what to do about it. Thank you, Mr. Chairman.

Mr. **Hughes**. Thank you, Mr. Chairman. I want to welcome the witnesses.

I found it extremely interesting in listening to the dialog insofar as the cooperation and the sharing of information, and while in the last few years I have seen some degree of cooperation, particularly among law enforcement, it is just amazing to me how little strategy has been developed in this particular area. For instance, it might be of interest to my colleagues to know that the Department of Education is not even a member of the policy board because that is law-enforcement-oriented, and so the Department of Education is not even represented. If you ask the average law enforcement officer how he would deal with the drug problem today, they would indicate to you that they would spend more money on education.

But if I ask you who it is who is making that decision as to how on the national level we allocate resources among our efforts overseas in eradication of crops institution, interdiction, education, and in treatment, can you tell me who makes those decisions?

Dr. JAFFE. I can't tell you who.

Mr. HUGHES. Can you, Mr. Westrate?

Mr. WESTRATE. Well, sir, our policy board——

Mr. HUGHES. Well, how can they do that without the Department of Education being represented or NIDA being represented? NIDA was invited to some of the meetings at the Department of Human Services, but is NIDA giving direct influence into that budgetary decision?

Dr. JAFFE. I cannot answer about the budgetary——

Mr. HUGHES. Well, I can tell you that there is nobody, but nobody in this Government that is making decisions as to how we are going to allocate resources. We all agree that it has to be a full court press; that we have to deal with the international problems, we have to deal with interdiction, intelligence gathering and in eradication and in treatment. There is nobody looking at the total picture, and that is the problem. That has been the problem now for the last 5 years that I have been working directly in this area that nobody is making those decisions.

Now, Mr. Westrate, you have indicated to us that one of the things we have got to do is commit more resources. Now the crack problem presents just the most recent problem, and after this there is going to be another problem, and all we do is we keep moving resources around instead of committing more resources. In the area of education and treatment we ought to be ashamed of ourselves as a partner.

We absolutely dump these problems on the community is what we are doing, because we are not spending anywhere near what we should be spending. We have gone from $370 million in 1981 in treatment and in education down to $40 million—$40 million. I got that from Health and Human Services. We have gone from $370 million down to $40 million.

Dr. JAFFE. Does that count the block grants?

Mr. HUGHES. That counts the—well, when you say block grants——

Dr. JAFFE. There are millions of dollars——

Mr. HUGHES [continuing]. We have put together a whole host of programs and let the community decide how they are going to spend the money, and in many instances there is no assurance they are spending the money in the area of drug abuse.

Dr. JAFFE. There is a requirement with the block grant for States to spend a certain amount on drug abuse.

Mr. HUGHES. Can you tell me how much money the Federal Government is spending on treatment today? You tell me if you want to quarrel with the figure.

Dr. JAFFE. The Federal Government's direct expenditures on treatment are now related to expenditures by the Veterans' Administration and the Department of Defense.

Mr. HUGHES. No; I am talking about in the civilian sector. What are we spending on treatment today? How much money?

Dr. JAFFE. I would have to look at the value of the block grant because approximately 50 percent is used for substance abuse, and it is estimated that approximately 50 percent of the substance abuse money is spent on drug abuse alone.

Mr. HUGHES. Give me a figure.

Dr. JAFFE. The block grant estimate is $117 million for drugs.

Chairman MILLER. Would the gentleman yield?

Mr. HUGHES. I yield.

Chairman MILLER. Let us be very clear about that. That's about half of what it was in 1980.

Dr. JAFFE. I don't know what it was in 1980. I can't say.

Chairman MILLER. I'm talking about the direct expenditure. The direct expenditure from the block grant for federally assisted prevention and treatment programs is half of what it was in 1980, and this panel started out by telling us how the problem has escalated and tripled since 1980.

Mr. HUGHES. How much are we spending directly, not through block grant? How much money is the Federal Government spending on treatment?

Dr. JAFFE. According to my numbers, $103 million.

Mr. HUGHES. The block grant.

Dr. JAFFE. Not the block grant; direct Federal funding. The block grant drug estimate is $117 million.

Mr. HUGHES. Break that down for me. How is that being spent?

Dr. JAFFE. How is which being spent?

Mr. HUGHES. How much is being spent for the Veterans' Administration. How much DOD?

Dr. JAFFE. Of the $103 million?

Mr. HUGHES. Yes.

Dr. JAFFE. I do not have that breakdown, but we can provide that for you for the record.

Mr. HUGHES. How about in the area of education? How much is the Federal Government spending in the area of drug abuse education?

Dr. JAFFE. The figure I have in front of me is $20 million.

Mr. HUGHES. $20 million. What was it in 1980?

Dr. JAFFE. I do not have that figure in front of me.

Mr. HUGHES. Well, I can tell you that the figures I have seen indicate that it has gone down markedly at the same time that the problem has increased markedly. Do we have a program that is directed to the youngsters in the elementary schools?

Dr. JAFFE. I believe we have several, sir.

Mr. HUGHES. And how much are we spending on that program?

Dr. JAFFE. I don't have the breakdown, but we can get that for you for the record.

Mr. SCHEUER. Will my colleague yield?

Mr. HUGHES. I'd be happy to yield.

Mr. SCHEUER. It is my understanding that the Department of Education has a budget of about $18 billion, and of that they are spending approximately $3 million on drug education, one-sixtieth of 1 percent. I won't ask any further questions. The obvious questions suggest themselves, because I am on my colleague's time. One-sixtieth of 1 percent of the education budget on drug abuse education, when perhaps the main cause of education failure, the main cause of education dropoutism, the main cause of crippling and disabling kids in their educational life is drug addiction.

We spend one-sixtieth of 1 percent of the education budget in meeting that direct threat to education success in this country.

Mr. HUGHES. Just don't feel as if it is unique from the standpoint of education and treatment because we have the same problem in operations, law enforcement operations. Of course crack has us extremely concerned, but if you look at the same DAWN reports, it shows us that we have tripled the incidence of deaths and overdoses as a result of crack in the last year or so.

If you look at what is happening in the area of prescription drugs, 65 percent of the overdose in deaths according to the DAWN reports doesn't come from heroin, doesn't come from cocaine, doesn't come from marijuana, it comes from prescription drugs. Those are the drugs that the kids are abusing and we are losing every day throughout the country. What is the Federal response to that, Mr. Westrate, to deal with that problem?

What does the Drug Enforcement Administration spend on the diversion problem?

Mr. WESTRATE. I believe your figures are correct in terms of 65 percent at one time, but that is now decreasing to about 50 percent, but I think the point is well taken. We have, of course, a very aggressive program—diversion control program—as you know.

Mr. HUGHES. In fact it is so aggressive that in 1982 in the budget cycle when our problem was probably at its peak with prescription drugs, and the Federal Government had diversion investigative units in place—they were very effective—they were so good we eliminated them, and we have no diversion investigative units. We have no Federal leverage today to deal with that particular problem, and we keep moving resources around from one problem to the other, and we are operating in a margin.

We are not doing a good job overseas because we are not committing enough resources to crop substitution and eradication. We can certainly use more resources there. There was a proposal not to use the foreign cooperative investigative program. Cut back on our intelligence gathering in host countries, not to use the manpower there. We haven't expanded our task force operations because we don't have resources to do that.

We have never revived in any way the diversion investigative units, and the fact of the matter is that we really haven't done a very good job in any of the areas. Even though the law enforcement community, and I am familiar most with that, has done, I think, a superior job with the resources they have, we are operating in the margin, and we haven't gotten serious about the problem. Until we do, we are not going to deal with the problem.

Nobody is in charge. There is nobody looking at the total picture and saying we have a massive drug problem, and to deal with it we are going to commit this amount of resources to education, this amount of resources to treatment after determining just what our shortfalls are. We are going to beef up our operations in source countries and commit the resources we need there and commit the resources we need on the southern border, if you want to call it a border. I mean 32 percent of the cocaine is now coming across the southern border, and people coming across at will, and they are carrying, in many instances, all kinds of contraband including cocaine. Thirty-two percent of cocaine is coming across our southern border almost at will now.

Mr. WESTRATE. Mr. Hughes, I would agree with you that we are operating on the margin in many of these areas, but we have had some resource enhancements, as you know, at least on the enforcement side, and I can tell you from personal and daily experience——

Mr. HUGHES. Compared to what, Mr. Westrate? If you want to go back to 1981 and 1982, that cycle where we actually lost major ground. Have we really recouped in some areas what we lost in 1982?

Mr. WESTRATE. Yes, we have recouped to the point that we were in special agent strength, and now we are ahead of where we have ever been in history, and I think you have to consider such things also that this administration also brought 1,000—actually 1,100 work-years into drug investigative activities. We have the Organized Crime Drug Enforcement Task Force Program.

Our resources have in fact increased, but the problem, as you say, has us on the margin.

Mr. HUGHES. Mr. Westrate, what we do when we commit FBI resources, and it has made some improvement in our caseload, is we take those resources away from other areas. We dump on the States the bank robberies. We decline prosecution of bank robbery cases. I mean we can't suggest the FBI wasn't busy before we, in fact, put them into substance abuse work and drug interdiction. What we did was we moved those resources from other areas, white collar crime and a whole host of other missions, and we put those missions on the back burner just like we now propose to do with crack.

That doesn't mean I don't support an effort to try to develop task force operations because I probably would because it does make sense since that is the newest crisis we have. But the problem is it is crisis management. We move resources from other areas to deal with the most recent crisis instead of trying to deal with it realistically. We should be beefing up our border operations right now to deal with those problems, not just undocumented aliens.

In the last 6 months we have had aliens from 55 countries come across our southern border. We reached our millionth alien on May 22, millionth, and for every alien we catch, one plus comes into the country. Thirty-two percent of our cocaine is coming across our southern border. God only knows what else is coming across the southern border.

We don't have the resources to deal with the problem. We don't have the resources to deal with the undocumented aliens. We don't have the resources to deal with all kinds of crime being committed there, and nobody is looking at the total picture. A few years ago it was proposed by Senator Biden and others—I know the chairman and the ranking minority member, Mr. Gilman, joined with us on the House side in trying to develop a drug czar to put somebody in charge of the overall problem, but because of a lot of turf battles, including DEA, DEA had problems with it, and the FBI had problems with it and Customs had problems with it.

They thought it was going to erode their territory, their turf, and as a result it was vetoed by the President, but it would have done something that we should have done 5 years ago, and we would be much further ahead if we had somebody in charge much like with the Vice President in charge of the South Florida Task Force. Things were done because you had somebody in charge, and when the Vice President said I want five Customs agents in Miami tomorrow, they were in Miami tomorrow.

Nobody is allocating resources in that fashion to deal with this malady, and until we make up our minds we are going to get serious about it and put somebody in charge who has some credibility and that can talk to NIDA and get the data and put that to good use and not worry that it ends up in Carlton Turner's office not being utilized in a fashion that will bring some strategy to bear on the problem, we are not going to realistically deal with the problem.

Chairman MILLER. The gentleman's time has expired.

Mr. HUGHES. Thank you, Mr. Chairman.

Chairman MILLER. Congressman Fish.

Mr. FISH. Thank you, Mr. Chairman. I am very pleased at some of the things I have been hearing. This, of course, is the hearing room of the Committee on the Judiciary where three times in the last 5 years we have reported out immigration reform legislation, and its relevance to the topic today has been mentioned by several of my colleagues, I certainly hope this means that we will be moving forward and finally give the Nation what it wants in terms of immigration reform.

Mr. Westrate, in your prepared testimony you talk about actions that DEA is involved in overseas, particularly in Latin America eradicating coca plants, destroying cocaine base and hydrochloride laboratories. You talk about the cooperation of other nations as necessary to the control of chemicals and you mention Operation Stop Crop and Operation Pipeline.

I would like you to comment on a statement of an authority in this field, and that is once the leaves of the coca plant are harvested, there is little that can be done. It is too late to keep the product out of the United States.

Mr. WESTRATE. Well, no, I wouldn't agree with that. Eradication I would say, however, is a very very important strategy that we have to pursue on cocaine in particular. We have proven it effective in other areas. Once the leaf is harvested, we have many opportunities and we do take them to interdict cocaine in route to the United States.

The leaf, of course, is turned into coca paste. That in turn is turned into cocaine base and then subsequently into cocaine hydrochloride. All of these activities take chemicals. They take people. They take laboratory sites, electric generators and so forth. So our first opportunities, which we have done very successfully in the chemical control program, is to locate and seize laboratories and to deny the traffickers these chemicals.

Our next opportunity, of course, comes through the interdiction activities as cocaine is in route to the United States. In the Miami Division of DEA alone last year, which includes the Bahamas, we seized 50,500 pounds of cocaine. Now I say we, that is all law enforcement and our foreign counterparts together. So that is a major opportunity.

Then, of course, we have the investigative opportunities for investigating the trafficking groups and so there are many opportunities, and we take them. We arrested 16,000 people for trafficking violations in the United States last year.

Mr. FISH. Well, in the source country itself, then, you don't subscribe to the theory that there is an invisible government in several of these countries, and the visible government is corrupt, and that you cannot really do the expected enforcement job that you are describing to be effective.

Mr. WESTRATE. No, not at all, we do have some problems in terms of getting our programs implemented, but we are making, I think, great progress. Colombia has been an outstanding example. Equador is working very effectively. Peru and Bolivia, both, are cooperating quite well now on both eradication and interdiction programs. Frankly, I am quite encouraged about the potential in South America.

Mr. FISH. I'm glad to hear that.

Dr. Jaffe, last year NIDA announced plans for a nationwide media campaign schedule beginning January 1986 and targeting 18 to 35-year-olds as its primary audience. I wonder if you could summarize briefly the accomplishments of this effort.

Dr. JAFFE. That campaign began on time—the spots are here if you wish to see them—all indications are that it has been an exceedingly successful campaign based on people's response to it, as well as the number of people calling in to hot lines saying they have seen the media spots and been stimulated by them. It may very well be that our problem now is to quickly mount something that would be as effective for young people who are perhaps more vulnerable to this new form of smoked cocaine. I believe that is on the drawing board.

Mr. FISH. That is being developed, because we do hear about the increasing numbers of elementary school age children using cocaine, and I wondered if it wouldn't be a good idea to drop the target age of your audience.

Dr. JAFFE. The basis for deciding on the original target group was based on the fact that they were the groups that were using cocaine the most. We had done the research. We had tried to understand what might be the most effective message, and it was on that basis that the campaign was developed. I'm not sure whether we have all the information we need to make a very effective campaign directed at young people of, say, 12 to 18 years of age.

We will move ahead with what we have, but the smoking of crack is such a recent phenomenon that it is difficult to assure you that the campaign directed at young people will be as effective. We hope it will. It is proceeding in any event.

Mr. FISH. One other area that I don't think has been adequately gone into in this hearing has to do with treatment and prevention, and I wonder if you would care to comment on what treatment and prevention approaches have thus far been identified by HHS and by NIDA as being the most effective in dealing with cocaine abuse.

Dr. JAFFE. Dealing with cocaine abuse specifically makes it more difficult to answer. Much of NIDA's work in terms of its diverse approach to cocaine and to drugs in general has been based on the observation that there is a gateway series of behaviors. Young people start with smoking and they proceed to alcohol and then to marijuana and then on to things like cocaine.

Therefore, one major effort that NIDA is researching and attempting to implement is aimed at preventing young people from experimenting with any drugs, including tobacco, and alcohol. We hope that by delaying the onset of drug experimentation, we can bring people to a level where their judgment may be more mature. There are other approaches being looked at as well.

We have been working with parents groups extensively because we feel that without that kind of grassroots support, without the involvement of the family, a simple cognitive education about information will be relatively ineffective. We are also proceeding, as you know, with a variety of information campaigns and media campaigns.

A major initiative that has been worked out very recently involves a commitment by a group called the 4 A's, the American Association of Advertising Agencies, that will involve a commitment of about $1½ billion of advertising time and talent with the goal of "unselling" America on drugs.

Dr. Macdonald and Dr. Schuster have been working with members of the 4As to finalize agreements to set the process moving. We hope to see much wider use of mass media to do as much to unsell drug use as the advertising community is able to sell a variety of consumer goods. We feel that that kind of massive commitment will make a significant impact in the area of prevention.

Mr. Fish. Thank you very much, Doctor.

Chairman Rangel. Mr. Scheuer.

Mr. Scheuer. Dr. Jaffe, you are talking about a massive commitment on drug education from where?

Dr. Jaffe. The private sector.

Mr. Scheuer. The private sector.

Would you say the Federal Government, which is now spending about one-sixtieth of 1 percent of its education budget on drug education is giving the kind of leadership that would be necessary to motivate and stimulate the private sector?

Dr. Jaffe. With all due respect, I decline to comment on how the Department of Education should allocate its resources. I will try to answer for the National Institute on Drug Abuse.

Mr. Scheuer. Do you know any significant drug education program now that the Department of Education is sponsoring or supporting or financing?

Dr. Jaffe. I know Dr. Macdonald and Dr. Schuster have been having discussions with the Department of Education, but I cannot presently identify such a program. We can produce it for the record if it exists.

Mr. Scheuer. All right, if it exists and you think they may be having discussions.

Dr. Jaffe, you are one of the most brilliant leaders in this whole drug field and have been for at least a decade and a half. If my memory serves, in 1971 you became director of an office called SAODAP, the Special Action Office of Drug Abuse Programs at the White House; is that correct?

Dr. **Jaffe**. That's correct.

Mr. **Scheuer**. That legislation, incidentally, I take some pride in. It was sponsored by Senator Muskie in the Senate and myself in the House, and you performed magnificently.

Wouldn't you say that after 15 years of your personal leadership in the field of drug abuse, it is a little bit pitiful for us to be discussing this morning that the Federal Government is discussing the possibility of doing something in drug education?

I don't want to put words in your mouth, but what has happened to our country? Tell us what has happened in those 15 years. At least when you took over that job in the White House, we had some leadership. We had some direction. We were able to go to the mountaintop. You were the mountaintop, and you did allocate resources and you did provide drive and leadership. Where is that focus of leadership and drive today?

Dr. **Jaffe**. Let me say that at that time it was the sense of crisis that I think was precipitated as much by our concern about heroin use among our troops in Vietnam as the epidemic that had preceded it by several years.

Mr. **Scheuer**. Dr. Jaffe, do you detect any lack of a sense of crisis among the committee members on both sides?

Dr. **Jaffe**. I have a feeling that the current epidemic of crack use among young people may be a similar kind of crisis and may lead to some reassessment, strategy development and some new initiatives. I can't say that for certain. That's not my role. I think these are times when the country coalesces and people can agree on a common agenda. Since you brought up my other life, let me point out that there was as much resistance to urine testing as a device to discourage heroin use among the troops in Vietnam as there is now in the civilian population. The difference was there was sufficient sense of crisis to implement that testing. You have heard from other witnesses there is still ambivalence about using that particular approach in other populations.

Mr. **Scheuer**. Well, look, my time is limited. I don't want to get down to that level. What I am trying to do is have you take us to the mountaintop and tell us where we are going. I must confess I was inordinately disappointed at your colleague's testimony when he says they had a very successful year last year, and he gave us some figures on what they picked up in the way of cocaine.

May I ask you what percentage of all of the narcotic drugs coming into this country do you think you picked up? Was it 5 percent? Was it 7 percent, 3 percent? What do you think you have picked up?

Mr. **Westrate**. Well, sir, as we have testified several times before, we don't know exactly how much.

Mr. **Scheuer**. Just give us a rough ballpark estimate.

Mr. **Westrate**. It is very difficult to do that.

Mr. **Scheuer**. Just give us a rough ballpark estimate.

Mr. **Westrate**. I would say between 10 and 30 percent.

Mr. **Scheuer**. Now, you are not suggesting to us here that you have picked up anywhere near 30 percent, or 25 percent, or 20 percent, or 15 percent, or 10 percent, of the narcotic drugs that are coming across our borders. Are you seriously suggesting that?

Mr. WESTRATE. Well, I can tell 50,000 pounds of cocaine is an enormous amount. I think in the marijuana——

Mr. SCHEUER. But you go into any town and hamlet and city in the United States, and you can get all the cocaine that you want. We haven't had a law enforcement expert testify before our committee in the last couple of years that we are picking up more than 5 or at the most 10 percent, and you preen yourself here that you had a very successful year last year, and you tell us that you are quite encouraged at what is happening in South America. You must be the Dr. Pangloss of the day if you can take any encouragement at what is happening in South America as far as drug trafficking is concerned.

I am utterly depressed to hear this kind of naivete and this kind of illusion coming from a leader of the DEA. It is utterly depressing, the lack of realism, the lack of hard-headed professionalism that should lead you to say that you are picking up anywhere from 10 to 30 percent. That statistic is incredible on its face, and it robs you of the credibility that you should have as the leader of DEA.

Now let me ask Dr. Jaffe—we are in a continuing crisis. Our kids in school are being drowned in this epidemic of drug addiction. It is probably more responsible for school failure, for defeat in life for young kids, especially minority kids, than any other phenomenon in our society. It is a truism that drug addiction is responsible for perhaps a half—55 or 60 percent of the violent crime in our urban centers, so it is a destabilizing fact in urban life, but it is a crippling and disabling event in the life of millions of our kids.

Looking at the whole spectrum of the travel of drugs from the poppy fields of Southeast Asia, or the coca trees of Latin America, into the arms of our kids in our communities, where would you say that society ought to look for a target of opportunity? The eradication program has been largely a failure—some spotty successes, but basically it hasn't worked.

The interdiction program, I have never heard a law enforcement professional in my life in the last 15 years that I have been on this committee state that more than 5 or at the most 10 percent of the drugs coming in have been apprehended at the borders. For the first time in the last year or two at our hearings that Chairman Rangel has brilliantly chaired, law enforcement official after law enforcement official has said for the first time that this has got to be something that is addressed on the demand side. The supply side is out of control, and they tell you in the next breath, we can't reduce funding for interdiction efforts, but the answer does not lie there, it has got to lie in drug education. It has got to lie in convincing kids that life is a high and getting involved in that whole black world of drugs is going to destroy their lives.

How do we do this? Give us of your wisdom, of your 15 years of brilliant leadership and involvement in every aspect of the drug program. Tell us why are we in this situation today when guys like you have been out there counseling us, observing, studying, scholars, activists of whom you are one of the deans. With talents like yours guiding us and advising us, how did we get into this mess? How come we weren't able to make serious inroads on this problem, and where do we go now?

Dr. JAFFE. It is a very broad question, but let me say that——

Mr. SCHEUER. Your shoulders are broader than my question.

Dr. JAFFE. Well, you are very kind. I think it may be necessary not to abandon any of those. If you talk to treatment people, they will tell you as long as there are drugs on the street, it is hard to do rehabilitation, that you have to work on all of it. I think that an education program is certainly an essential part of the demand reduction side, but it may not be all of it.

Certainly there are people wise enough to know that they are taking risks. It may very well be that it is an issue of attitude. You might talk about it as individual discipline, individual responsibility. It may be that we have to target more on the individual user. I can tell you from a previous experience that when we weighed all these factors, when it really came down to trying to stop the use of drugs in the military, the consequences even of experimentation had to be made something that caused the users to give some pause. To stop and think; not about the more remote possibility that they might die, but the more probable possibility that, if others might know about their use, and there could be some consequences they might not like.

These didn't have to be Draconian penalities. They didn't have to be disastrous. We didn't have to threaten to send people to prison for 1,000 years, but just the idea that if you use drugs it was probable that something you won't like will happen. That something may simply be that you have to go into a treatment program. In effect, that set of contingencies is working in the military. The extent of drug use, because they have random urine testing is lower than it is in the general population, although the group from which the military is drawn is certainly not immune to the kinds of seduction that goes with drug use in the general population. Now, one would hope that in a country like ours it would be unnecessary to do things of that sort. But you can see that even in professional sports the commissioners saying that athletes could lose one-half of a million dollars in salaries for abusing drugs.

We recently sponsored a conference on drug abuse in the workplace which provided a forum for industry and others in the private sector to get together to focus on policy that may take us over a crisis. One can't say how long these kinds of epidemics last. One looks back in history and they appear to go up and down. But that may be one approach. Certainly it is not a substitute, however, for sound education; for making people aware of the dangers. I might point out to you that the tragedy of two healthy and promising sports stars dying from cocaine has produced perhaps more exposure to the real dangers of cocaine than we have purchased through Government efforts in the last year. The end result is, hopefully, that people are now aware that even snorting cocaine can kill.

People are also now aware that it is not just that you get addicted to cocaine, but you can have a heart attack, a stroke, or cardiac arrhythmia. Those things are now known. It is a little early to know whether all the publicity is going to have much of an impact, and it is a very complex issue that is not easily solved. It is a struggle I think we are going to have to deal with for years to come because in a free society there are always people who are seduced the easy pleasure without giving very much thought to the pain that may come.

Young people are perhaps more at risk for that, but as we also see those who grew up in an easy generation, those that are now, let's say, between 18 and 40, also have a more relaxed attitude toward drug use. I might point out, though, something that some of us did not expect, that some of the education does seem to be having impact. It is not all 100 percent bleak.

As little as 5 years ago, 10 percent of young people were using marijuana on a daily basis. That has now dropped down to 5 percent—that's progress. It is somewhat paradoxical that that should happen in the face of a growing cocaine epidemic, but it is there, and the data are there, and for a while we thought we were on the right track. That decline has stalled, and we need to look at it again, but it very well may be, to answer your question bluntly, it is not an issue of shifting resources so much as recognizing that somehow we have to make the individuals who use drugs feel the sense of responsibility both to themselves, their families and frankly to their country.

People who buy drugs, are taking the capital out of this country, are not doing themselves any favor and not doing their country any favor. Apart from any risks to themselves, not being good citizens and somehow we have to do something about that. How Congress and the Executive Branch and the Judiciary will get together on those areas which touch on issues of individual freedom and privacy and how to get drug abuse under control is something that I can't answer, but it is certainly an area that needs to be looked at.

Mr. SCHEUER. Well, I agree with you. Along with these drug abuse programs and sex abuse programs we ought to have a self-esteem program. When people begin to think good about themselves, they won't abuse themselves in any of these ways.

My last question would be—you mentioned that there are improvements in the marijuana situation; that we have cut by half the rate at which young kids are using marijuana.

Dr. JAFFE. On a daily basis.

Mr. SCHEUER. On a daily basis. Are there any elements of that phenomenon, anything that we did to make it happen like topsy? Or, were there things that Government did at any level or things that the private community did that we can learn from? Are there elements that we can extract and perhaps apply that knowledge to a reduction of heroin and cocaine and crack?

Dr. JAFFE. Well, we have in fact been applying them. The question is when does it begin to have its impact? The inference was made on watching the turnaround in marijuana. In the early seventies, there was a general feeling that marijuana was innocuous; that nobody became dependent on it, nobody used it every day or was addicted. It took some time to turn around that perception among young people, and it took a lot of research to establish that, in fact, marijuana does have significant serious downside problems.

Now the same thing has happened with cocaine. People have forgotten history. In the beginning of this century, doctors were very concerned about cocaine. It was a risky drug, and you only have to look into the text books of the 1920's to realize what respect doctors showed cocaine because of its unpredictable toxicity. Somehow it was forgotten. Somehow with people making movies about how funny it is to sneeze and blow away the cocaine—it was trivialized. It may take some time before people realize the seriousness and the respect that one has to show to such an overpoweringly addictive substance, one which is so risky in terms of safety that even the Addiction Research Center, which I now head, didn't undertake research on cocaine until 2 years ago. It seems to be too risky a drug, too hard to know when it will cause an arrhythmia.

We have been capitalizing on those risks in our media campign, trying to get more data on cocaine toxicity, trying to get out the message that people do become drug addicted in the sense of what we mean by addiction: an overwhelming need to use the drug, and trying to dispell the myth that cocaine is a drug that can be used with impunity. Now how long it takes to turn around perceptions is not clear. There is always a view among experimenters that you can get away with it.

Until the appearance of crack, those of us working on this issue had the feeling that maybe we were making some progress. I think that crack is going to make us reassess that feeling because it takes a whole new vulnerable group and gives them access to a cheap drug that produces an intense high. But we were applying that message. If you can get out the realistic, honest facts about the downside risk, eventually people hear the message and change, and eventually the attitude that it is OK to use changes. I think that is changing. There has been a change in attitude toward drug use in general as can be seen with attitudes toward marijuana, and as can be seen with attitudes towards other drugs. A number of them are showing downturns. Cocaine is an exception, and it is an awesome and frightening exception.

Mr. **Scheuer**. Well, Dr. Jaffe, let me simply state my admiration to you and my appreciation on behalf of the public for the exemplary leadership that you have given this effort of fighting drug addiction in our country. You have done it over a period of at least a decade and a half, to my knowledge. You had an astonishing leadership role that you have played to the hilt, and I am grateful to you on behalf of the American public.

Dr. **Jaffe**. Thank you.

Mr. **Scheuer**. Thank you, Mr. Chairman.

Chairman **Rangel**. Mr. Coughlin.

Mr. **Coughlin**. Thank you, Mr. Chairman, and let me thank the witnesses for their patience. It is sometimes easy to be dramatic from this side of the podium, and we appreciate your patience here.

First, Mr. Westrate, a followup on a question by Mr. Fish. The coca leaf is grown only in South America, and I guess from personal observation I really despair at the hope of crop eradication because it is grown mainly by poor cappacinos who are out in very remote parts of the country. I also despair somewhat on drug interdiction, despite the fact that in another subcommittee I appropriate millions of dollars for the Coast Guard to try to interdict drugs coming into this country, but cocaine is so compact and so compressed in such a small quantity and so potent, that interdicting it is, I think, a very difficult problem.

The real choke point, at least in the opinion of this member, is the processing laboratories mainly in Colombia that convert coca paste into cocaine hydrochloride. They are readily identifiable because they emit a lot of infrared. With our technology we can identify them. With a number of relatively small light aircraft we could locate them. With some helicopter support to countries like Colombia we could take authorities in there and eradicate those processing facilities. They usually have clandestine airstrips affiliated with them, and I guess my question is are we making any real progress in that area?

Are we getting cooperation from the governments down there? Why with a very limited amount of resources can't we get to this choke point and have a very significant impact on cocaine which is the basis of crack.

Mr. **Westrate**. Well, I would agree with what you have said, and, yes, we are getting cooperation. Operation Stop Prop and Operation Chem-Con, which I referred to earlier, are principle programs that are devoted exactly to that. Many lab seizures have been made and we continue to pursue that as one of our principle strategies.

We have seen a trend in the past couple of years, though, that particularly as the ether program became successful that the traffickers began to ship cocaine base to the United States and convert it to hydrochloride in labs in the United States. I think we seized 22 cocaine laboratories last year, so they are able to adjust.

We are also finding them shifting their laboratories from traditional areas into other areas in Brazil, Ecuador and that kind of movement. So they do react to the pressure and are able to set up other labs, but it certainly is one of our key areas.

Mr. **Coughlin**. There was a rash, I know, last year at about this time of seizures of laboratories in Colombia and on the Peruvian border and in southern Ecuador. But I have seen not an awful lot of reporting of that since then. Has that continued?

Mr. **Westrate**. Yes, we have continuing programs, and we are very active at this time doing the same thing.

Mr. **Coughlin**. And just one question, then, to Dr. Jaffe. Again in another subcommittee in which I am the ranking member, we have conducted, I think, an immensely successful program on drunk driving. Now you can't drive down a highway today without seeing a billboard on drunk driving. You hardly can go through an evening of television or radio without hearing something about drunk driving, and we need the same kind of effort on cocaine.

Cocaine kills. We know that just like drunk driving kills, and yet I don't see the evidence of that kind of campaign. How do we get that started?

Dr. **Jaffe**. The message that "cocaine kills" is something that I think is being started from the tragedy of Len Bias and other sports people. But the message that cocaine is addictive and dangerous became our official media campaign earlier this year—Cocaine—The Big Lie. We think this campaign is very effective. I worked on part of its development. Now the question is how do we get the maximum air time? How do we get people to put on these spots to get those messages out?

Mr. **Coughlin**. Can we take a lesson from the drunk driving campaign?

Dr. **Jaffe**. Well, to the extent that we can mobilize the various elements of the private sector. I can't say where the resources came from or how it was arranged to get the attention of the communities the issue of drunk driving.

Mr. **Coughlin**. Isn't it worth taking a look at that campaign and seeing if we can model a campaign on cocaine killing after the drunk driving bill?

Dr. **Jaffe**. I think we need to get as much exposure to the message about cocaine as we can. We will certainly take your comment to heart and look at how they are managing to get as much exposure for the drunk driving messages.

Mr. **Coughlin**. Because we are doing a terrific job in that area. We really are. Here is another area that is equally killing and one that deserves the same kind of approach. Please look at it.

Dr. **Jaffe**. Thank you. I will.

Mr. **Coughlin**. Thank you, Mr. Chairman.

Chairman **Rangel**. We are going to adjourn for 15 minutes because there is a vote on. But before we do, Mr. Westrate, we are going to have some representatives from the local police departments. I wonder whether you can give us what your idea is as to the responsibility as relates to law enforcement in dealing with these drugs. I mean assuming that your guesstimate of 30 percent was correct, what basically we are saying is that 70 percent of the drugs on the street are coming in from outside the United States, and since there has not been any increase in the DEA agents over the last decade, what role do you see the Federal law enforcement playing as relates to local law enforcement?

Mr. **Westrate**. Mr. Chairman, we have looked at this question over the years as a cooperative division of labor. Now, there are certain things that State and local law enforcement are better equipped to do, and there are certain things that the Federal law enforcement, like the international efforts are better equipped.

Chairman **Rangel**. Forget the international. I am talking about people who are selling drugs, arresting them, taking them to court and putting them in jail, that type of thing.

Mr. **Westrate**. Well, it would certainly be our belief that the State and local agencies have a tremendous responsibility in that regard.

Chairman **Rangel**. They seem to think that the Federal Government believes they have all of the responsibilities where the Feds deal with high level type of conspiracies and international transactions, but that you should not expect too much direct assistance for the street trafficker and that type of thing.

Mr. **Westrate**. Well, I think that is valid in the usual circumstance accepting we have some special concern such as crack. I think that we do have a responsibility at the Federal level to coordinate, cooperate and assist in measured response in that area.

Chairman **Rangel**. Why do you see a difference between crack and the cocaine that comes in anyway? It is just a question of processing and packaging. Why would you see any special need for the Federal Government to give assistance to local police for crack as opposed to heroin and cocaine?

Mr. **Westrate**. Because I think the special seriousness of this fast rising phenomenon is important and anything that can be done to blunt that expansion is critical, and if we can contribute to doing that, I think that is our responsibility to do so.

Chairman RANGEL. What do you see as this increased contribution? What form will it take?

Mr. WESTRATE. Well, as I mentioned before we have responsibility to share intelligence. We are doing a survey which will be appropriate. We are considering potential legislation that might be useful, if necessary, on prosecuting crack houses although there is quite a debate about that. There a number of things that we can do from the Federal level to assist with this problem.

Chairman RANGEL. From a law enforcement prospective would you support more Federal assistance in terms of resources going to local and State officials that relates to crack?

Mr. WESTRATE. To the extent that it doesn't significantly deteriorate from our responsibilities and working major traffickers. We have to keep in mind, as you mentioned——

Chairman RANGEL. Strike that out. I meant that the Congress would appropriate direct financial and resource assistance to local and State police, not detracting from the Federal effort. Do you think something like that would be helpful from a law enforcement perspective?

Mr. WESTRATE. Well, Mr. Chairman, all of these questions are questions of priority and resources. So if there were to be some kind of an appropriation that would create a program to work only on street level activities and not diminish the efforts at the smuggling and trafficking organizations——

Chairman RANGEL. Let me try again, Mr. Westrate. As a Member of Congress, I am just trying to take advantage of your expertise in law enforcement. I'll have enough experience on this side in terms of dealing with the deficit. But do you believe that it would make any sense for the Congress to get the appropriations, you know, without detracting from our national defense or security to give more assistance to our local police from a law enforcement prospective. Do you think that that makes any sense?

Mr. WESTRATE. Well, I would certainly say that they could use the extra resources to address the problem, but I think we have got to keep resources focused on the answers, and not lose sight of the fact that crack is in fact a different form of use. We must not lose our emphasis on the production and transshipment and smuggling aspects of the cocaine problem.

Chairman RANGEL. These people aren't being arrested. I mean they are still on the streets. There are jails to be built. There are courts, judges, prosecutors, you know, the people in the street don't understand all this coca jungles. Would DEA support giving assistance to local law enforcement? More specifically could you support H.R. 526 which allocates some $715 million for that purpose?

Mr. WESTRATE. I can't speak to the specific bill, but I would certainly support resource enhancements to State and local enforcement agencies.

Chairman RANGEL. Thank you. We will stand adjourned for 15 minutes.

[Recess.]

Chairman RANGEL. The Select Narcotic Committee will come to order. I would like to thank this panel for its patience with the committee as you could see and hear. There was a lot of interest and concern about the testimony that had been taken earlier.

I think to some degree all of your testimony deals with the outbreak of crack, and without getting involved in the chemistry of it and the international nature of it, it would be very helpful to this committee if you could share with us how big the problem is, what you are doing about it, and what you would want your Congress to do in being of assistance.

I see that Chief Turner has sent Isaac Fullwood, who is the assistant chief that certainly is well known to all of us in the Congress; Wilhelmina Holliday, the deputy commissioner from my city, the city of New York; and Joel Gilliam, who we thank for coming all the way from the Detroit Police Department. He is the inspector in charge of the narcotic division. So if we can hear from Chief Fullwood—what we hope you will do is to try to stick with the 5-minute rule, and without objection, your entire testimony will appear in the record at this point.

Chief Fullwood.

TESTIMONY OF ISAAC FULLWOOD, ASSISTANT CHIEF OF POLICE, WASHINGTON, DC, METROPOLITAN POLICE DEPARTMENT, ACCOMPANIED BY CHRIST CULLIGAN, INSPECTOR, MORALS DIVISION

Mr. Fullwood. Thank you, Mr. Chairman, members of the Select Committee on Narcotics Abuse and Control and the Select Committee on Children, Youth, and Families. I appreciate the opportunity to be here today for the purpose of testifying about the prevalence, use, and trafficking of crack, a relatively new and deadly form of cocaine in the District of Columbia. I would also like to discuss the involvement of school-aged youth in the abuse and trafficking of illegal substance and to share some of our ideas and recommendations to prevent the use and distribution of crack as well as other narcotics.

Recently, there has been widespread publicity about crack, which is cocaine that has been distilled from its familiar powder form, cocaine hydrochloride, and resembles small rocks and is the color of soap in appearance. Crack is the cheap and deadly cocaine which is smoked, and because of this method of ingestion into the body, it is highly addictive.

Crack use and distribution have reportedly reached crisis proportions in Los Angeles, Miami, Houston, Detroit, and New York City. However, locally in the Washington, DC, area, crack is not at this time a serious problem. It is just beginning to surface on the streets at our drug market locations. We have submitted approximately 20 exhibits of suspected crack to the Drug Enforcement Administration Mid-Atlantic Laboratory for analysis. The director of the Mid-Atlantic Laboratory, which also provides analytical services for the DEA, FBI, and U.S. Park Police and several other Federal agencies, reports that these agencies combined have submitted very few suspected crack exhibits for analysis.

Even though we are not presently experiencing a crack crisis in our city, I fear that it still remains as a very serious threat. Because crack is cocaine base, the amount of crack available in a community is naturally related to cocaine availability. Cocaine is readily available and extensively abused in the Washington, DC, area.

In prior years cocaine was abused primarily as a drug of the affluent, and the expense of the drug at about $100 per gram limited the extent of abuse. However, due to the abundant availability of cocaine and the reduction in price now ranging from $20 to $50, cocaine has now become a leading drug of choice. We now find violators selling cocaine from more than 20 street locations throughout our city.

Cocaine arrests have increased 600 percent from fiscal year 1982 when 334 persons were arrested for cocaine charges to fiscal year 1985 when 1,923 persons were arrested on similar charges. Juvenile arrests for cocaine offenses are also increasing. In calendar 1985 there were 883 juveniles arrested for various drug charges. Out of this total 132 or nearly 16 percent of the arrests involved cocaine. The majority of the cocaine arrests—111—were felony arrests involving distribution of the drug.

We also recovered over $43,000 from the juveniles incidental to their drug arrests. From January 1 through July 8, 1986, we have arrested 527 juveniles on various drug charges. Out of this total 105 or nearly 20 percent of the arrests involved cocaine. The majority of the cocaine arrests—91—were felony arrests involving distribution related incidents. So far this year we have recovered over $34,000 in out-of-the-pocket money from the juveniles incidental to their drug arrests.

Based on these statistics it is readily apparent that more and more juveniles are becoming actively involved in the illicit drug trade not only as users, but also as drug traffickers. The juvenile age group most often being arrested on drug charges is 17 years of age and a high school drop out. If attending school, juveniles being arrested are mainly in the ninth grade. It is difficult to identify the number of juvenile drug abusers in the District of Columbia, but according to undercover officers who were assigned to several of our high schools, drug abuse is widespread among the students.

Even though juvenile arrests involving cocaine are high and continuing to increase, PCP is the drug most often abused and distributed by juveniles. As a matter of fact 65 percent of all juvenile drug arrests are for PCP related charges and the vast majority involve distribution of the drug.

Currently, heroin is identified as the worst drug being abused because it is the drug most often introduced into the body intravenously. It is highly addictive. It causes most drug overdose deaths, and it is identified as being a leading cause of other crime. There have been several studies conducted to determine the relationship between heroin addiction and crime. All studies that I am familiar with have all reached the same conclusion—that heroin addicts live a life of crime to support their addiction. A 1985 study of heroin users in east and central Harlem found that the annual crime rate for these heroin users was 1,075 crimes per annum.

In comparing crack to heroin, we find that crack is more addictive and more craving than heroin and there are reports of continued use to exhaustion by some abusers. Even though crack is less expensive than heroin, the intense craving and continuous use makes a crack habit more expensive to support than a heroin habit. The abuser must then depend on money from his family and his friends or resort to an assortment of various crimes to support his habit. Police departments in other jurisdictions where crack is readily available and highly abused report increases in crime. Therefore, it is anticipated that crack addiction will cause an increase in crime in the Washington, DC, area.

Essentially, the problem of drug abuse, whether it be crack or any other illicit substance within our country can be viewed from two perspectives: the supply side and the demand side. Each area is critical to any overall effort in stemming the tide of rampant drug abuse, and it is equally critical that a proper balance be struck between enforcement, education and treatment efforts.

How can we effectively combat the drug problem facing this Nation? Prevention, we believe, is the best approach. On the Federal level, the U.S. Government must encourage and assist foreign governments of producer countries to undertake crop control programs thereby reducing the production of illegal drugs at the source. For example, our experience at the street level subsequent to Turkey's 1972 poppy ban and Mexico's 1975 poppy eradication programs at the source of the product had a dramatic impact on the purity percentage and ready availability of heroin in our communities.

It is therefore critical that the international community focus upon and find better ways to resolve drug issues. We must be able to seize assets, homes, automobiles, banks, bank accounts derived from drug trafficking. We have to develop better intelligence activities and solicit greater support from the government of producer countries. We must work diligently toward the highest possible conviction rate of drug traffickers and the ultimate destruction of their criminal organization.

Effective coordination and full cooperation among the Federal, State, and local law enforcement agencies are essential to any effort directed at the importation, manufacture, and sale of illicit drugs within the United States. Aggressive interdiction and investigation, effective prosecutions, stiff prison penalities, seizures of assets are essential to controlling drug trafficking.

The community, in aiding law enforcement, must refuse to participate in purchasing illegal drugs. They must say no to drugs. We must make available all information to discourage consumption. As long as the demand for drugs remains high in the community, the dealer will attempt to sell his merchandise due to the enormous profit involved in illicit drug activities.

Mr. Chairman, at this point I will terminate my statement so I can stay within the time. I think that there is no greater problem facing us than the problem of drug abuse. People die from it. Our young people—we are losing a generation of young people, and if we are to make any great effort, we must do it in terms of preventing our young people from becoming involved in this death that occurs. We must encourage people to say no to drugs.

Law enforcement has to arrest, but we have also got to be involved in a total approach to dealing with the problem of substance abuse.

Chairman RANGEL. Thank you, Chief.

Deputy Commissioner Wilhelmina Holliday, we welcome you to the Nation's Capital.

TESTIMONY OF WILHELMINA E. HOLLIDAY, DEPUTY COMMISSIONER FOR COMMUNITY AFFAIRS, NEW YORK CITY POLICE DEPARTMENT, ACCOMPANIED BY FRANCIS C. HALL, CHIEF, NARCOTICS DIVISION, NEW YORK CITY POLICE DEPARTMENT

Ms. HOLLIDAY. Thank you. Let me first thank the honorable members of this committee for the opportunity to come before you to outline the dimensions of the problems that are related to cocaine free base known as crack in New York.

Before I continue, I would like you to know that this is Deputy Chief Francis Hall, the commanding officer for the narcotics division in New York City, not Mr. Gilliam. I think they have made that correct.

This new drug, the derivative of cocaine hydrochloride, is extremely easy to make, is widely distributed in New York City and elsewhere. It is cheap to make, cheap to buy, and devastating in its results. It is considered by the experts to be particularly dangerous because it is quick to act on the brain and extremely strong and quickly addictive. While regular cocaine, for example, can take 3 to 10 minutes to take effect, the effects of free base cocaine or crack is felt within 3 to 10 seconds.

Moreover the feelings of euphoria are deep and intense. While the initial stages of crack may produce what users consider desirable feelings, the end result is often devastatingly dangerous—feelings of paranoia, extreme violence, and wild behavior. Often, too, the use of this drug is combined with other legal and illegal drugs such as alcohol, heroin, marijuana and other drugs, and it sometimes leads to tragic accidents.

We find that crack came to New York City from Los Angeles where it first made its appearance in 1981. That's according to our sources. It first made its appearance in the New York City Police Department laboratories for analysis in January 1985, but it may have come to the city as early as 1984. Crack is not a local phenomenon, of course, and it has been reported in many areas of the Nation since its first appearance in the early eighties.

We know from previous testimony that it is derived from the coca plant which is grown in South America and then smuggled into the United States in various forms, usually as pure cocaine. Arrested crack dealers in New York City report that the trade is brisk. One green vial of the drug sells on the street for about $10, and users consume an average of five such vials during one session. There may be several such sessions a day for each user. A hit of crack may last a user as long as 5 to 10 minutes which increases the consumption of the drug because the feeling does not last long.

Crack houses, places where users may congregate to use the drug, are springing up everywhere in New York. Aside from the illegal sale and use of the drug, the crack houses may also be the center of other crimes. The New York City Police Department has instituted an anticrack drive recently. Less than 2 months ago, on May 21, Commissioner Benjamin Ward and the mayor of the city announced the formation of the 101 Officers Operation to suppress the traffic in this drug.

As of April 22, that special unit has arrested 303 individuals, closed 11 crack houses and managed to locate 1 crack factory. They have also seized more than 1,700 vials of crack, 174 tins of cocaine, 235 pounds of marijuana, and a large quantity of drug-related materials plus more than $22,000 in cash. The size and dimensions of the crack phenomenon are just now becoming clear to law enforcement. On May 18 of this year, for example, the police department's laboratory began to record the analysis of crack separately from other drugs.

During the period May 18 through May 31, 1986, the New York City Police Department laboratory recorded that out of a total of 1,105 cocaine analyses performed, fully 752 of those analyses, about 68 percent, involved crack. Judging by our arrest records, crack is becoming the most available and most popular drug of choice on the streets of the city. It surpasses even heroin or marijuana.

In January of this year there were recorded 330 arrests for crack-related crime in the city of New York. That was before the special anticrack unit went into existence. In June of this year, after the crack team went to work, we recorded 674 crack-related arrests. It is just the beginning.

Aside from the special anticrack effort, the police department has engaged the crack problem in other ways. The school program to educate and control drug abuse, SPECDA, has added a special crack component to its educational efforts. During the past school year, the SPECDA program reached more than a quarter of a million of school age youngsters in such specialized focused programs as a fifth and sixth grade classroom educational sessions, as well as school assembly programs specifically tailored for elementary schools, junior and intermediate schools and high school. There are also workshop sessions for parents, as well as close cooperative efforts with the city's board of education. Other SPECDA programs such as Officer Mac, a talking robot for younger children and similar approaches help us to penetrate the most vulnerable potential market for drug users. The idea behind SPECDA is to make a strong effort to reach youngsters before the drug dealers and other negative influences do, to prevent their going on to a life of drug abuse.

We deem the program a success and look forward to expanding it to 16 school districts. We feel that the more information that the children have, the more negative an attitude toward drug abuse we can help them to develop, the lest chance that there will be for these youngsters to make a life of substance abuse. Naturally crack is now a major concern in SPECDA.

The enforcement side of SPECDA has made thus far 173 cocaine-related arrests within two city blocks of public schools just during the month of May. Of those 173 arrests, 127 involved crack. There have been 1,056 crack-related arrests in the city of New York since the beginning of the year to the end of May, and many more arrests of that kind are anticipated. The police department has asked the State legislature to change laws regarding narcotics crimes to make it easier to arrest crack sellers and users with small quantities of the drug. We await that legislative action.

There are programs dealing with the suppression of narcotics traffic which have had the effect of the phenomenon of crack added to our burden. We are now determined to continue these efforts. We have made thousands of drug-related arrests in many localized programs, but as Police Commissioner Ben Ward noted before this very panel in November of last year, we cannot be satisfied with arrests alone. We must cut down the demand for drugs in New York City.

I enthusiastically endorse Commissioner Ward's view of this matter. I wish to add my own voice to the commissioners and to applaud the efforts of this committee in trying to suppress the hateful drug, and as the deputy commissioner for community affairs, I also note with some satisfaction that the Honorable Mr. Rangel, in a recent letter to the New York Times, asked that the community join with him in pointing out the drug problem including the crack plague and crimes associated with crack.

It is not merely a local problem, but one which demands the attention of higher authority. I thank you for inviting me here to present this, and I would like any other questions to be directed to me and the chief of the narcotics division.

[The statement of Ms. Holliday appears on p. 159.]

Chairman RANGEL. Thank you. We will now hear from Inspector Joel Gilliam from the narcotics section of the Detroit Police Department. We thank him for his well-documented article which will be put into the record without objection at this point.

TESTIMONY OF JOEL GILLIAM, INSPECTOR, NARCOTICS DIVISION, DETROIT POLICE DEPARTMENT

Mr. GILLIAM. Thank you, Mr. Chairman. As my colleagues have already well-stated before me, I would like to give you a thumbnail sketch within the allotted time for making comments.

First of all, the Detroit Police Department, Narcotics Section, is a centralized enforcement unit charged with the 24-hour enforcement of the violation of the narcotics laws within the corporate limits of the city of Detroit. That dubious distinction has given us a rather street wise, if you will, understanding of the problem. I know when a Federal program fails because the streets of Detroit are flooded with brown or glassine envelopes containing cocaine. We know what it is to be considered under attack, if you will, because at 960 times last year, the narcotics section raided narcotics houses, primarily cocaine houses. In one of those raids we had the unfortunate experience of losing an experienced narcotics officer.

By any stretch of the imagination, we are in a war. The committee may join us now or join us later. It is simply a matter of time. What we feel is going on is that the age group that is abusing this drug—now it is crack. Probably before that it was rock. Before that it was cocaine powder. Before that it was heroin. Before that it was marijuana, but what we have found is that we have to keep our sights on the proper perspective, and that is that we know to some degree what causes the addiction in the age groups that we are talking about.

I make it very clear in my testimony that we believe that by the time a youngster has reached the age of 12 to 13, he has already reached a decision to use these substances, so any education or treatment has to be directed at an age group from kindergarten to sixth grade. Any other efforts, in our opinion, are a waste of time and good money. The city of Detroit Police Department invests through the administration of the mayor and the chief of police many many hours of manpower and much of the resources of our city to fighting this problem. At best we are only slowing the rate of increase.

I can only predict that as we go forward from these hearings that we will be able to come up with a, hopefully, national direction on what is to be done with this problem, because there are many many aspects to it. There is a monster loose in the cities of this great Nation, and it is only up to the concerted efforts of each of us that we will get a handle and put him in a cage where he belongs.

I thank the committee.

[The statement of Mr. Gilliam appears on p. 169.]

Chairman **Rangel**. Thank you, Inspector. You mentioned that we were at war, and I wonder about that. I know we are under attack, and Mr. Gilman was sharing with me some dramatic illustrations of kids in your town being paid on a daily basis to sell drugs.

Mr. **Gilliam**. Yes.

Chairman **Rangel**. Besides talking about how many are out there selling and how many people are getting arrested, what would you as a law enforcement officer say to this committee is necessary if we really are going to believe we are at war? In other words, all of law enforcement are talking about reduction in demand. I can understand that, and it won't surprise me if all the Federal officers and local officers are going to be in the churches and in the classrooms.

But before we were public officials, we used to be in the street, and you go in the street—the person in the street hasn't the slightest idea and cares less as to whether you represent the Washington Police Department or the Drug Enforcement Administration or whatever, or the FBI. Now they think that the politicians and the police are part of the problem because people are still dealing.

Now, I know how frustrating it is. I only have a 2-year contract as a Member of Congress, but you are a commanding officer in charge of the narcotic section, and when you go back to the street when they can see the kids are buying and selling. The more you arrest, the more people that are out there, the more judges can't put them in jail, and the jails are swollen.

Isn't there a time when you get together with your brother inspectors or superior officers around the country and talk about this being a war, because what you are doing today, you have done last week and you are going to do it next week and I am assuming that even if you learn to do it better that it is not really going to have much effect on how much drugs are in the street.

Mr. **Gilliam**. Mr. Chairman, we could close every drug house in the city of Detroit, bar none, and it would do no good, because you are going to end up with an identifiable number of addicted people to a substance that if it is not available at a certain price, they will only go out and get the money to pay for it at a higher price. If you would only be available on the streets at $50 a day, a crack cocaine habit which is not an exorbitant habit, costs $18,250 a year, 365 days to support. Where is a ninth grade dropout getting $18,250 a year from?

Chairman RA[illegible]. But how do you explain—if you are the person that looks like you are in charge of eliminating this problem and carry the title and recognize in all of your frustration how many men that you have actually lost, have given up their lives, the hours that are put in, the people that the courts are letting out, but I mean if it is a war, what do you do? Who do you talk with, and what makes you think that the country thinks that you are at war?

I mean has the Drug Enforcement Administration come in there and said this isn't just your responsibility. I'm your partner—I mean are there law enforcement officers in the street? Do you see State programs directed at reduction of demand? Do you see any light at the end of the tunnel?

Mr. GILLIAM. No, sir.

Chairman RANGEL. Well, let me ask Chief Fullwood—one point you say in your testimony on the last page, "Communities must organize programs which encourage people to provide information anonymously, if necessary, or report the observance of suspicious activity." I mean just from the subway home I could write volumes, but I care too much for Commissioner Ward to send that type of stuff to him.

I could give him a map and just circle the whole area and just say, "Work with it." But realistically no matter how much he increases his arrest records, I don't think that he expects that it is going to lessen the quantity, indeed the quality of drugs that are on the street.

Is any different in the District of Columbia? Can you really handle this program here in the District, you and the police chief and the mayor?

Mr. FULLWOOD. I would like to think that we are at war, but I don't really believe that. I think that when you are at war you use all your resources to fight the war. You don't take a straw and try to stop a tank. You have to have tanks to stop tanks, and I don't believe that we are at war.

I think that we are doing, on the local level, as much as we can within the constraints that we have. I think that there has got to be massive support from the Federal side to bring the problem of drugs under control, and I think the Federal Government has to use the war machinery to stop drugs from coming into the country.

If you look at it statistically, and you start talking about arrests, if you look back at 1981 in the District of Columbia, we made over 6,800 arrests. In 1985 we made over 11,000 arrests, and the problem of drugs go unabated. There are more drugs on the street now than there have ever been. There is more cocaine on the street now than there has ever been, not due to any lack of action by the mayor within the constraints that he has. The problem is massive. The problem is massive for every city as each one of the members at this table has said. It is a massive problem.

We have tried to do a variety of things. On the enforcement side we make arrests. On the education side we go into schools, as you indicated and do all kinds of things, but the problem goes unabated.

Chairman RANGEL. I am a former foot soldier in the infantry, and everyone is talking about war, but from time to time we did see a general or a colonel or something, and I can't for the life of me see how, in talking with police chiefs, how they feel compelled to show how many arrests they have made, and how sometimes the criminal justice system is clogged or how they are not keeping them in jail, or how early the kids are exposed to it. But it just seems to me that if you knew—and I know you know—that people expect that the buck stops with you—you are the policeman.

You know that the problem is bigger than your block, your precinct, your command, your city, and yet sometimes I think the silence is almost deafening as we see the police chiefs marching like good soldiers doing the best they can with what they have to work with, and this administration clearly telling you, which I hope all of you heard, that in their opinion it is a local and State law enforcement problem. I mean the man said it, and they all will tell you that they will do the best they can with high-level conspiracies, with task forces. At one point we had more people in task forces in New York City than the Feds did until the police chief had another look at it.

But be that as it may, we are raising hell and talking with foreigners. We are raising hell with high-level conspiracies, whatever that means, but I don't see anybody making any undercover buys. Chief Hall, you know, in the 1960's people didn't know who was going to arrest them, whether it was going to be a Federal Bureau Narcotic agent, whether it was going to be a State officer or a New York City cop.

Is there a Federal presence on the street in terms of arrest and prosecution?

Mr. HALL. Not that I am aware of, Mr. Chairman. The Federal effort in New York City is devoted primarily to mid- and high-level dealers. I'm not aware of Drug Enforcement or FBI people that are actually addressing the street problem of narcotics.

Chairman RANGEL. Don't you remember when it used to be competitive as to who stole the case from the city?

Mr. HALL. Well, the prosecution end is still competitive, Mr. Chairman.

Chairman RANGEL. Well, I don't know. My U.S. attorney seems like every time he arrests someone for drugs he has a press conference. I would like to laud him for enforcing the Federal narcotic laws, but we used to accept that as a part of the responsibility of the U.S. Attorney's Office when I was one of them. Now it seems they go in and make buys and get some releases out, but I don't think that the U.S. Attorney's Office or the Federal Bureau of Investigation or the Drug Enforcement Administration represents any threat at all to the people we are talking about. That is what I am asking. I mean I don't hear anyone saying that they are afraid that the Feds are going to catch them.

Is there a Federal presence in Detroit?

Mr. GILLIAM. Detroit, Mr. Chairman, sits on an international border, and I think we have more Federal agencies in Detroit than you have here in this city. And, I can tell you right now that narcotics enforcement within the corporate limits of the city of Detroit is a local police department effort, not saying that we don't have support at the middle to upper echelon because at that level we are talking about Title III wiretaps and a whole lot of other things, which the State of Michigan does not have a wiretap law.

But when you talk about stopping 100,000 packets of cocaine and stopping bulk in the kilogram form, then you are talking about apples and oranges.

Chairman RANGEL. Well, I guess what I am trying to say is that I just assumed that all of you belong to national associations and that you share common problems, and indeed if we are talking about an international crisis this has to be the one of our generation. If you truly believe as I do, and the committee members, that we are under attack, then I would hope that you would be able to come up with some recommendations to the Congress or at least to support in a very positive way some of the legislation that we have out there, because it seems to me that you are foot soldiers. You are out there on the frontline and the Federal Government is telling you that as far as they can see it is a local and State problem.

I am frightened to death because I think, traditionally, police chiefs or superior officers believe that speaking on certain of these issues sounds as though it is political, and of course many of the mayors that appoint don't want police chiefs talking more than the mayors, which is impossible if you come from the city of New York.

I do hope you can find some way to give your Congress some support because you have heard it today. Education is a local and State matter. We have made no commitments, and the Secretary of Education has a $3 million allotment out of $18 billion. You have also heard today we don't expect, at least this year, and some of us believe the next 10 years, certainly in the next 5 years a decrease in what is being produced, and so whatever we do in education and law enforcement, unless we get more help from the Federal Government, I don't think the statistical data is going to be any better than what it has been.

Mr. Guarini.

Mr. GUARINI. Thank you, Mr. Chairman. From the local level, in your perspective, how much more help do you need from the Federal Government to do your job better? Is the cooperation of the Federal Government given you adequate? Are we working as a team or are we working in subdivided pigeon hole boxes where we are all trying to do our respective jobs and working on our own individual turfs? Is there a coordinated partnership that we have gotten addressing this problem in your opinion?

Does anyone want to respond to that?

Mr. GILLIAM. Well, I think, Congressman, one of the things that we have seen, at least at the street level, is that to a large degree I really don't know what the Federal Government is doing. And what I mean by that is, is there a national policy on drugs that we all can see and is a well thought out plan that can be supported at the State, local, and Federal level? I don't know if there is. I am not a member of any such collective effort.

Is there a mandatory type of State law across the land that enforces these types of things? I don't know. I think if you look from State to State you will find that they deal with it pretty much based on how much experience they are having at any given time. So my concern right now is that if you are asking is there a national policy on drug eradication, stopping, arresting and all of that, no, sir, there is not.

Mr. GUARINI. So actually what we are really missing is a national strategy in attacking this problem in its entirety; we are fragmenting our efforts, overlapping our efforts and getting a very poor result.

Mr. GILLIAM. If there is 100,000 jurisdictions out there, you have got 100,000 plans.

Mr. GUARINI. What has been your experience in dealing with your State officials and your Federal officials in regard to solving your local problems, say, in Detroit? Is there a jealously of turf, or is it a total cooperation in trying to get to the bottom of the problem?

Mr. GILLIAM. No; I think there is a clear division of labor. I think if you look up and down the ladder what you will find is that the city of Detroit has a mandate to protect the citizens of that city, and we do it pretty much with the resources that we have. If there is a State effort, it is more or less done by providing us with the laws that have to be in place because this city cannot pass felony-type laws of conviction. That's a State function.

At the Federal level I know of no law that impacts on my jurisdiction. I don't know if it does anyone else's.

Mr. GUARINI. So what you are saying is that there is an overlapping of efforts, there is a waste of energies and there is a lack of resolve in getting to the heart of the problem.

Mr. GILLIAM. I am saying there is no one in control—yes, sir.

Mr. GUARINI. In New York, Commissioner, do you have the same thoughts that our friend from Detroit has?

Ms. HOLLIDAY. Similar. We do reach out. Our commissioner reached out to the other agencies, but the commitment is not the same as New York City.

I spoke in my presentation about our 101 unit. The New York City Police Department committed 80 of those persons in that unit from the New York City Police Department. The others came from State and Federal. But clearly when you see an 80 and 101, you see that the commitment was local.

Mr. GUARINI. So actually we are not making the best use of our resources in addressing the problem.

Ms. HOLLIDAY. To some degree, yes.

Mr. GUARINI. Chief Hall, do you have an opinion?

Mr. HALL. I was sort of shocked and dismayed when I heard—I believe it was Congressman Scheuer mention earlier and the chairman that out of the budget of $18 billion, the Federal education budget, only $3 million goes to drug education, and those of us in law enforcement, this is the direction we are going today. If there is a solution to this problem, it lies in education.

The SPECDA budget in New York City alone, the School Program Education on Controlled Drug Abuse is $3½ million, so the paltry sum of $3 million out of a budget of $18 million is nothing short of outrageous.

Mr. GUARINI. Well, do any of your police departments have education programs that reach down into the schools and have adult level seminars so that you can use your expertise in bringing in a meaningful way—I just don't mean having a couple of classes—a program to the people?

Ms. HOLLIDAY. I think we can be very proud of the New York City program, SPECDA Program, School Program to Educate and Control Drug Abuse, and it represents, for the first time, two super agencies coming together--the Board of Education and the New York City Police Department—coming together and making that kind of plan and commitment, a 50-50 commitment. Our police officers along with the drug counselors that are with the board of education are in the classrooms, fifth and sixth grades.

We have a 16-week drug prevention course that we are there regularly with the youngsters. We have also an assembly program with the junior high school and high school level and we have parent workshops. So we started out as a pilot project just in two school districts. There were many people in the community and in the school communities indicating that there was a great need, so we had increased to seven school districts.

As of September, we will be in 16 school districts. There are 32 school districts in New York City, so we will reach approximately a half million youngsters with this drug program.

Mr. GUARINI. Yes. Are the children getting involved themselves and putting together their own program working with the adults? Or is it just reaching down to the children?

Ms. HOLLIDAY. We are combining it. We are working with the youngsters. We are working with the parents. We are working with the teachers. We are training our police officers in drug prevention curriculum as well as with the counselors. We are combining our curriculum with the board of education.

I brought a sample of our packet. That is our SPECDA Program. It goes out. The youngster takes material home. We have it, as I said, in the fifth grade for 8 weeks and in the sixth grade for another 8 weeks, then we back this up, and by the time they reach junior high school, they are trained. We have our robot with the younger school children.

Mr. GUARINI. Now have you found that to be very effective?

Ms. HOLLIDAY. Yes.

Mr. GUARINI. Not as a program, but have you evaluated the effectiveness of the program?

Ms. HOLLIDAY. This program was evaluated by John Jay College, and the evaluation was excellent. In fact, they felt they were embarrassed because they could not find anything negative about the program.

Mr. GUARINI. All right, last, let me just ask you about crack. As I understand it, this has reached widespread use among adults. Has crack got any hold on the children or is it more the middle-aged people that seem to be interested in the crack phenomenon?

Mr. GILLIAM. Congressman, we have found that it is 12 years old and dropping. The first use is 12. It is dropping. We anticipate by this time next year we will be down into the 11-year-old age group, and that is a phenomenon that is unprecedented with any other drug that we have been able to identify.

The problem with crack is we don't have a measuring stick that we can come before a concerned body such as this select committee and be able to tell you it is something like heroin was in 1970. Well, that don't fit. Or it is something like marijuana was back in 1950. That don't fit, so there is no measuring stick that we can put before this select committee and tell you that is what we are dealing with. We don't know. Ten months ago, it wasn't even in the streets of Detroit, and now it constitutes 85 percent of our enforcement effort.

Mr. GUARINI. We know the problem. We have identified it. We know we don't have a national strategy, but are there recommendations that you people can make to this committee as to things that could be done? I know you need resources and money and you are probably short on that, especially with the Gramm-Rudman problems that we have today and probably with the fact that a lot of things are being thrown back on the local communities where the Federal Government was previously picking up the tab.

But are there any concrete recommendations that any of you could make that you see from your perspective that would be helpful to us?

Mr. GILLIAM. There is one.

Mr. GUARINI. Yes.

Mr. GILLIAM. I think the select committee should find out if there is a Federal forfeiture or asset removal law, and those funds are not going back into the fight against the problem from which they are coming; namely, the drug dealers paying for the fight against or the financing of a drug substance abuse education program. My understanding is those funds may be going into the general fund, and if they are, that would be a travesty.

Mr. GUARINI. Does anyone else want to address the question? Is there anything concrete you could recommend or suggest?

Mr. HALL. One thing appears obvious, sir. In New York City alone we made over 50,000 drug-related arrests in 1985, and I must honestly say that the condition in the city has not improved.

Mr. GUARINI. You don't have enough jails to put the people in, do you?

Mr. HALL. That is part of the problem. There is only 35,000 jail spaces in New York State. I have recently said if I was a physician treating a patient and getting the same results, I would be sued for malpractice.

It is obvious to me that the direction in which we are going is not the solution to the problem. We are making these massive number of arrests. A few people are being incarcerated, and the results are nil, and it appears to be a Parkinson's law of principles in narcotic enforcement. The more resources you put into the problem, the greater the problem becomes.

That's why, if there is a solution at all, sir, it lays in education. That is a long-term solution. It is an expensive solution, but it is a path we must follow. If we don't, the next 10 years are going to bring disaster to the United States, in my opinion, sir.

Mr. GUARINI. Thank you. Well spoken.

Mr. GILMAN [presiding]. I thank the gentleman from New Jersey. The gentleman from New York, Mr. Fish.

Mr. FISH. Thank you, Mr. Chairman. I had an opportunity, Commissioner Holliday, to quickly read your testimony which we received today. I think there is a statement in there that you subscribe also to what we just heard; that education is the real hope for a long range solution to this issue.

Ms. HOLLIDAY. That's correct.

Mr. FISH. We have heard a lot about a lack of a strategy, and I think what we are talking about here is a strategy that involves everybody, not just levels of government, but the family and society generally.

Are any on the panel a member of one of these strike task forces that was modeled after the one in Miami involving Federal, State, and local law enforcement?

Mr. GILLIAM. The Great Lakes Task Force in Michigan, Ohio, Indiana, Kentucky, yes.

Mr. FISH. Your department is in that.

Mr. GILLIAM. Yes, sir.

Mr. FISH. Because you asked the question earlier about any Federal presence, isn't that the nature of the task force to have Federal, State, and local law enforcement people operating together?

Mr. GILLIAM. I think so. What we were dealing with was the street level of the problem, and task forces very rarely, if ever, at least in my experience, ever attack the problem at the street level. You are usually dealing with middle to upper level drug dealers when those task forces are created. At least that is my experience in Detroit.

Mr. FULLWOOD. We have had somewhat of a different experience. We do have the NPDA task force, and some of that activity is directed toward street level activity. Recently we had a case in upper northwest that turned out to be a major drug dealer, but it started out with the Federal Bureau of Investigation and one of the police districts working on a street level pusher. It turned out to be a major case, so we have had some cooperation.

The well is not deep enough. We just don't have enough resources to do it.

Mr. FISH. As my colleague from New Jersey said a few minutes ago, what really could come out of this hearing, and particularly this panel are recommendations to us. I don't mean we want you to just pop out with them, but this record will be kept open. I hope you will, as you think of things based on our questions and our search for ways in which we can structure a better strategy. It will be helpful.

As you all know, we are dealing with the question of the source country, improved intelligence, improved cooperation with the governments of source countries is important. There are indications that the military is going to be more involved in interdiction than they have been in the past under the constraints of posse comitatus. Our border problem is magnified by not being confined the Southwest only. The whole coastline of Florida, has a border patrol group that is responsible for it, and then you have Customs. But you get down to where people are hurt, and that is where you people come from, is the city streets.

Apparently to date these efforts in the source country, in interdiction, on our borders have simply not been successful in keeping this stuff out, so that really you would be helped. We have heard two things from you: The need for education, and that goes I guess, of course, to the demand side, not the supply side, which we are addressing. The forfeiture law, we have precedent in that in both Customs and Immigration law in terms of impoundment and sale of equipment—airplanes, trucks, cars, vehicles, and so forth.

Really, it would be enormously helpful if we could know from you on the firing line what more could be done. I think we know what is missing in these other areas that are plainly Federal jurisdictions dealing with foreign policy and dealing with the military, but what we can do actually to support local law enforcement is where we need help.

Mr. GILLIAM. I think there is one thing, Congressman, that we have been trying to do in the city of Detroit, and that is after looking at the problem from the various aspects of enforcement and the supply and demand side philosophy of the limited resources that we have at the city level, I think one of the things that we came up with is that this problem does not have a face on it. It is everybody and it is nobody. It is "them" out there doing it.

One of the major problems that we find is that a concerned and informed citizenry will probably be more understanding and tolerant of what we are doing in law enforcement if they understand what our problems are, and what we have attempted to do is put a face on the problem. Right now, who are the drug pushers? You know, it is kind of hard to fight a shadowy adversary, if you will, if you cannot at least come up with some kind of description of who he is or who it is. So that has been our main thing, and maybe if there can be some strategy of either making an identifiable person connected with the enforcement and the eradication and the education end, because as we put police officers in the schools in the city of Detroit, and we do that pretty much the way that New York does.

Our ministation program which is sort of like storefront police ministations, that is taking from the resources of the police department to put them into schools to educate the kids on substance abuse, and therefore is that right? Should our budget, if you will, be supplanted to go into this area? But then again the educational facilities or the board of education claims that they have a budget restraint and some other things. So then it comes down to who is going to get the job done, so there are some clear lines of problem there when you start breaking down to whose bailiwick is it, if you will.

Mr. FISH. Thank you, Mr. Chairman.

Chairman RANGEL [presiding]. Chairman Miller.

Chairman MILLER. I want to thank the panel for their participation. I think, building on what Chairman Rangel and Congressman Guarini and other members—every member of the panel, I think, has said, your voices need to be heard very loud and clear as we now start to come to grips with the formulation of a policy.

It is very clear that there is no policy at the moment. We have heard all morning that the White House is in a series of meetings today about how they are going to grapple with this, and that can range from a Presidential commission to something significant. We are clearly going to respond to this hearing in terms of congressional policy, initiative and it seems to me that law enforcement has got to bring forth their ideas so that we don't create a structure that really just makes your job more difficult.

If there are 100,000 jurisdictions and there are 100,000 plans, I would assume for the moment that they use their best thinking to figure out how to combat it in their area. I think one of the questions that we have to ask ourselves is how do we augment that? How do we make it more successful?

I think the SPECDA Program is very exciting, but I don't know how many fifth and sixth grade students there are in your jurisdiction, but all told there are more than a quarter of a million. We have got to get to those other kids. We have got to get to those other schools. It seems to me what we are talking about is a classic example of addressing the entire problem, and I don't think it is very glamorous. I think it is probably grunt work for most of your officers to figure out who is selling dope on the street, and what to do next and how to keep them off the streets and all of those decisions.

If we are going to put resources into this, it seems to me we ought to put them into a system that you tell us is going to make the most effective use of that dollar. I went through LEAA programs and others designed to enhance law enforcement, and I remember the conservations at the local level about trying to design a system to match the grant instead of having the grant match the problem.

It is clear to me that this issue is ripening on the national political agenda. It would be foolhardy, in the case of Medicare, when the doctors didn't want to participate in its design, if you did not participate now. The doctors, today, looking back, would have loved to have been the architects of it, and every year try to be. I think the question is whether you are going to be the tenants of the building or the architects of the building. Because I think in most jurisdictions what we are talking about is an expansion of already ongoing programs.

You would like to cover more street corners. You would like to cover more sections of your cities. You would like to have more neighborhoods. The question is, Is it really any more exotic than that? The President says this is a local problem. He is right. It is a local problem, in every jurisdiction in the United States of America, which makes it a national problem. We have local hunger problems, and we have Federal feeding programs. We have local housing problems, and we have Federal housing programs.

The fact of the matter is that we recognize that that is something that is of national importance. That is where we are today. I don't expect you to give me a recommendation at this hearing, but as we proceed down the road here, just as I expect the education establishment to give me recommendations about how best to use the educational systems, we need your voices raised a little bit. I sense that you may be a little timid on this.

The real question is how forceful are the law enforcement associations going to be in telling us what your real needs are? Not 80 percent, that is the welfare system. We only take 80 percent of something and give it to the people. What is it you need to really deal with this problem if we really believe that our constituents are as upset about it as we say we believe they are. If that is the case, then we ought not to do it on the cheap. We ought to do it right.

That is not a question you can respond to, but I am just concerned that we will go off and make a system up here that may just hinder you by the time you figure out what we did, because that is sort of how we address national emergencies around here. You know, we can't get the lifeboats in the water fast enough.

Thank you, Mr. Chairman.

Mr. GUARINI. I just have a curiosity about organized crime and crime that is not organized. Is the organized underworld official crime family involved in a larger or smaller share of the drug problem in our Nation from your perspective? Do you find that organized crime is moving in more, or do you think it is more of a distributorship of small families, Colombians and other disorganized distribution?

Mr. GILLIAM. In Detroit we find that our primary method of distribution is local family or extended family groups that have limited, if any, connection with the traditional organized crime figures. Now, that is to say that what we see in the streets of the city of Detroit are primarily those people that are in a predominately black community, and what we find is that when the Turkey crop was eradicated back in 1979-80, well that broke down the French connection, if you will, and Mexican brown started coming into the continental United States and ended up in the city of Detroit.

The Mexican connection ended up not being a Sicilian connection, and when the poppy fields of Turkey went back up and the white heroine again started showing back up on the streets of Detroit, they had lost their inroads into the neighborhood.

Mr. GUARINI. So what you are saying is that the power and money and force of the organized criminal element of our country has been setting aside this big business called drug trafficking and drug dealing, and is allowing the smaller families to come in and take over the distributorship; is that right?

Mr. GILLIAM. That appears to be the formation of the distribution setup in the city of Detroit. Now, this is not saying there are not some international importation of bulk.

Mr. GUARINI. I understand that.

Mr. GILLIAM. Yes, sir, you described it correctly.

Mr. GUARINI. Commissioner, how do you feel about New York, and how do we feel about Washington, DC, chief?

Mr. FULLWOOD. Well, in Washington, DC, it is probably the same kind of problem. What has happened is you have a lot of new entrepreneurs that crop up daily, because the drug business is the kind of business where anybody can go into business without the benefit of another person because drugs are just rampant. That is not to say that there are not occasions when we track heroin back to New York City and may track it back to the specific family. There is also that element.

You may break one organization tomorrow and five organizations crop up, so it is widespread.

Mr. GUARINI. Commissioner Holliday.

Ms. HOLLIDAY. It is widespread. Organized, the Italian element, is about 25 percent. The other is spread with black, Colombian, other groups. It is widespread.

Mr. GUARINI. So you think organized crime only has a 25-percent share of the drug trade as a guess?

Ms. Holliday. Yes, that's what our figures in New York indicate.

Mr. Guarini. Chief Hall.

Mr. Hall. The organized crime is still involved with the importation of heroin into New York City. We do notice, as Commissioner Holliday has said, the emergence of other groups that likewise organize—orientals, blacks, and Hispanics, who are heavily involved in cocaine trafficking because of the enormous profits involved. However, in the distribution and sale of crack at the street level, this has become a cottage industry. There are entrepreneurs involved. It is made in kitchens, as we all know, and it is being distributed by a host of people, including children of school age.

Mr. Guarini. Well, now that is the distribution part. But is organized crime lurking behind all the financing and promoting, or is it different ethnic families that may have taken over the business straight from the crop to the street?

Mr. Hall. We have to remember, sir, that of course crack is cocaine, and cocaine is imported from other countries, and at the importation level there is no question that organized crime is involved, not just the traditional organized crime, but the other groups.

We have reason to believe that oriental groups are now very heavily involved in the importation of cocaine.

Mr. Guarini. Are you saying that organized crime imports it basically, but it is dispensed with by small disorganized groups?

Mr. Hall. Organized crime always isolates and insulates themselves from the street level operations.

Mr. Guarini. So they are lurking behind the scenes and operating and pulling the strings of this whole big illegal, illicit industry?

Mr. Hall. Indeed. The young person selling crack on the street corner in New York knows little about the importation of that drug.

Mr. Gilliam. I think what we found in Detroit is that anybody with a four-engine airplane can go into the cocaine business, so I don't know how organized you have to be to get a clearance to fly down into that part of the world.

Mr. Guarini. So you have a disagreement about that.

Mr. Gilliam. I disagree to the extent where we are saying that organized crime is behind the importation of cocaine. I agree when the chief speaks of heroin. I think that is a more traditional drug for the organized crime organization, but I don't think that in cocaine, because of the large amount of the drug that is coming into this country across the international borders, southern borders of this country, that I don't think one person or one organization or group of organizations can keep track of it. It is just that much of it coming in.

Mr. Fullwood. I would agree with that. Based on many many arrests that have occurred, we have found just an everyday guy going down to South America and getting drugs or going to Florida and getting them and forming his own organization, so I don't think it is necessarily exclusively organized crime. I think heroin is. I think very definitely heroin is.

Mr. Guarini. Lastly, are there any trends in this direction? Is it such big business you find that there is a trend, or do you think organized crime is satisfied to stay in the background—finance it, arrange it, and let it be dispensed in the streets by different individual ethnic groups?

Mr. GILLIAM. I think what you are seeing now is that the turf wars, which is the battles for street corners in particular areas of distribution, are pretty much conflicts between one organization that is expanding or due to some police action or due to some accidental death, whatever, the leader of that organization is no longer available, and his territory is being absorbed by rival organizations, if you will, and therefore the turf wars or the shootings and the violence connected with this industry is pretty much a phenomenon within itself, and it has got nothing to do with, say, an organized group coming in and saying we are going to take over the west side of the city or something like that. I think it is almost impossible.

Mr. GUARINI. We saw in the bootlegging days in the twenties before the Volstead Act where there was this disorganized sense and gradually through the wars in the streets it got taken over by a few families, and then they made peace and then they had their own sense of an organization which we call the underworld today. But the fact is it did start out disjointed because it was profitable, but it grew into an organized arranged situation. I am just wondering whether or not we see that trend in narcotics and drugs today in our country. Does it follow the same pattern that we had in the world of liquor back 60 years ago?

Mr. GILLIAM. That phenomenon you mentioned may be in the future, but at this point in time there is so much of the drug out there that that is not a possibility at this point.

Mr. GUARINI. Thank you.

Mr. FULLWOOD. There is some cooperation among drug pushers. We found that in some cases that in major things they cooperate with each other.

Mr. GUARINI. Thank you, Mr. Chairman.

Chairman RANGEL. Mr. Gilman.

Mr. GILMAN. Mr. Chairman, I know our time is running. We are going to get out of here shortly. I would like to address the entire panel.

As some of us will be doing very shortly in meeting with our top administrative officials, they are going to be asking us what best can we do to combat this problem. I am addressing it now to the panel. If you had one response to give to that question: what best can we do to combat this problem. I'd like to go right through the panel.

Mr. GILLIAM. I think the first thing you have to do, Congressman, is that you have to understand that without a national policy, there will not be a national solution. What we are now seeing is that there are individual major metropolitan areas in the country that is experiencing a problem with cocaine presently being used in the crack form. That problem is like a pregnancy and will keep growing to other areas of the country, and it is only a matter of time before it reaches the hamlets and farms of this country. So all I am saying is that without a national strategy and someone in control of that strategy, we will not be able to effect it in a national way.

Mr. GILMAN. Thank you, Mr. Gilliam. Inspector Culligan.

Mr. CULLIGAN. One thing and the main thing that we have to do to get this terrible drug problem and drug abuse problem under control is that all segments, all agencies must come together in the prevention, the education, the enforcement, the prosecution of the crimes that are committed by drug traffickers and the problems that drug abusers have. We have to get together and coordinate more, and attack this problem in a single state of mind.

Mr. GILMAN. Thank you. Chief?

Mr. FULLWOOD. I come down on the side of education because I don't think that we have a national policy on how to approach educating our young people about the abuse of substance.

Mr. GILMAN. Well, our Secretary of Education says we ought to bounce them out of class and send them out of the schools.

Mr. FULLWOOD. Well, I don't agree with that. I don't think we ought to throw anybody out of school. We need them in there so we can get ahold of their minds, and we need to have a policy that is not weak; that goes straight to the problem that kids must say no to drugs, and we have got to support families and we have got to do that in a very straightforward way. We don't have a national policy now on education. We need to look at all the programs that are successful, adopt some programs and go after them and put the resources in.

Mr. GILMAN. Thank you, Chief. Commissioner Holliday.

Ms. HOLLIDAY. I would concur with that. My strong feeling is on the side of education, and we need a national policy. We have been attacking the drug problem in many ways locally in New York City, and I think, Congressman Rangel, you are aware of the many areas and the many programs that we have put into effect in the New York City area to combat this problem.

We had Pressure Point in the east side; Pressure Point 2 in the upper west side, Operation Clean Heights, and yet we see a greater proliferation of cocaine coming into our community and the effects and devastations of that. I am on the side of a national policy. We need national help, and a strong educational policy.

Mr. GILMAN. Thank you. Chief Hall.

Mr. HALL. We have 32 school districts in New York City. At the present time, Commissioner Holliday's program is only in 16. It is like being the parent of six children and only feeding three of them.

Mr. GILMAN. Why is that?

Mr. HALL. Money, sir. We need bucks. If we have the bucks we can do it. We can go into those schools and we can conduct the same program that we are conducting in 16 school districts today, and we shouldn't have to wait until 1988 or 1989. We should prepared to do it at the opening of the school year of 1986. We just don't have the bucks.

Mr. GILMAN. Thank you. I thank all the panelists for their time today and for their recommendations. Thank you, Mr. Chairman.

Chairman RANGEL. Well, our mayor was so proud of his balanced budget, I don't know whether or not we couldn't address that with some of the bucks in the city.

Please give my regards to Mayor Young in Detroit. I do hope that when the mayors get together before they got out on these conferences that somehow you might be able to get this crisis on their agenda. We are not going to win this as long as the feds are saying it is a local problem, and the local people are saying it is a Federal problem, and that appears to be the way we are going.

It just seems to me that some of you ought to get real mad about this thing and be able to collectively have a statement issue which doesn't do political damage to any of you individually, because I know how reluctant—you know, and probably for good cause, but we are here to work with you and not to get you in trouble, and I thank you for your patience and coming here to testify.

Mr. GILMAN. Mr. Chairman, just one comment. Mr. Gilliam, in his good report—we have read through it—in his recommendation No 3, it says, "The select committee should recognize that narcotics trafficking in this country is a major business." We recognize that. Amen.

Chairman RANGEL. Thank you.

Our last panel is Father Coleman Costello, executive director, Outreach Project from Rego, NY; John French, chief of office of data analysis and epidemiology, alcohol, narcotic and drug abuse unit, New Jersey State Department of Health; and our friend, Malcolm Lawrence, who formerly was the Special Assistant for International Narcotics Matters for the State Department.

TESTIMONY OF FATHER COLEMAN COSTELLO, EXECUTIVE DIRECTOR, OUTREACH PROJECT, REGO PARK, NY

Father COSTELLO. Good afternoon. I would like to submit my testimony and have it entered into the record. I would like to comment on some of the things I have heard today, starting with the ballooned T-shirt, saying no slogan type of approach to a major disaster that we have in this country.

I have been involved in this field of drug abuse for 19 years. I am a street priest. I work in the streets of Queens and of Brooklyn. I have seen an awful lot of kids and an awful lot of adults do drugs, and I have got to say that I am quite amazed at the inability of some of the panelists today, or the people who have appeared before this panel, I should say, to be so, in a sense, guarded in some of their comments to the questions that you have asked trying to find out and in order to be able to get a better understanding to the issue of drug abuse.

Mr. Scheuer's questions this morning about the amount of drugs that get into this country, the answers were interesting. It was stated that 15 to 30 percent of the drugs are stopped from coming into this country. My observation on that is that 70 percent of the drugs are getting into this country, and I also further suggest that if we are able to guard our borders with the U.S. Marines, our Armed Forces, if we are able to stop every drug from coming into this country, then we have to look at the State of California where the No. 1 crop is marijuana.

We have to look at our neighborhoods where angel dust is made. We have to look at things like white-out which is produced in this country—the secretarial white-out where kids are dying as a result of inhaling that particular substance.

I think we have a larger issue here, and the larger issue is that we have almost an antiyouth approach in this country to giving the kids in our country the services they need, starting with an educational system that will give them the skills in order, not only to complete school, but also to be able to use skills to enter into the world of work. We don't prepare our young people for the work scope.

We have issues like child abuse, kids in pain, kids who run away from home. The services for kids are very limited. So what I am seeing is an awful lot of kids are using drugs. When we ask the question why do kids use drugs? Because they are in pain—they are bored—there is no place to go. There is nothing to do, and that has been my experience in terms of communities' response has always been of kids are hanging out and they don't like it, they call the police, expecting that the police are going to solve the problem. It is more than just a police problem.

Something else I have noticed, too, on this project which I have started. We have a court department. An awful lot of kids enter into the criminal justice system. We heard some statistics today, just now, about the thousands of people who are arrested for the sale of drugs. These people who are convicted and who do go to jail, enter into a criminal justice system that is ill-prepared to really receive them, to give them the counseling and understanding of why they got themselves in that particular situation, and furthermore when they are leaving jail, they enter right back into the community not having the skills to really work and knowing the only trade they know, and that is selling drugs.

Who is the drug pusher? The drug pusher is our children. I see the need, I think, on the national level for us to start to look at all those questions, not just the issue of crack—crack being the drug we are seeing. As a matter of fact in my testimony, I say that 75 percent of the over 3,000 people a year we see at the outreach project are now using crack. I should say cocaine. Sixty-five percent are using crack, 5 percent bazooka, and 5 percent powdered cocaine, so that is a turnover from over 1½ years ago when the No. 1 drug coming into the outreach project was angel dust. So what I see is a cycle of different drugs. Maybe designer drugs next year, who knows? We don't know.

The fact is that there is no united strategy on the Federal level which is going to address what I feel is not so much the drug problem, but as the problem of our young people entering into a society that I feel is very antichild, and I see that in so many different ways from the world of work to the way we treat our kids, to the attitudes that parents have about kids. Parents need parenting skills. They need to be taught that at the earliest possible age.

The issue of teenage pregnancy is also another issue. If children are going to have children, then we have to give them the support that they need in order to be parents and perhaps adults. So I would just like to maybe end right there and pass it over to panelist two.

[The statement of Father Costello appears on p. 220.]

TESTIMONY OF JOHN FRENCH, CHIEF, OFFICE OF DATA ANALYSIS AND EPIDEMIOLOGY, ALCOHOL, NARCOTIC, AND DRUG ABUSE UNIT, NEW JERSEY STATE DEPARTMENT OF HEALTH

Mr. FRENCH. Thank you. I would like to say that I am grateful for the opportunity to appear before you today. Crack is becoming a major problem in New Jersey. As you know, Mr. Chairman, we are right south of you across the Hudson, and all of New York's problems eke right over to us.

Crack has come across in New Jersey with astounding rapidity. Last fall I talked to narcotics officers and drug users in northern Jersey who never even heard of it. Today in the major cities in north Jersey, the vast majority, 75 percent, of all cocaine arrests and seizures are crack. It is spreading southward, in fact, in the same way that the AIDS epidemic is spreading.

You have already heard today about the prices and purity of cocaine hydrochloride and crack, and there is a major point to be made about that. The differences in the prices and the purity provide an explanation for the rapid spread of that epidemic.

A kilo of cocaine hydrochloride in typical dilutions produces, as it moves through the distribution network, roughly-one quarter of a million dollars gross income. That same kilo, as it moves through and produces crack, comes up with roughly a gross income of $100,000. Those are very rough estimates, but they make a point, and the point is that the distribution network is taking a loss.

In a competitive market, the only explanation for that loss is an imbalance between supply and demand and it is very clear that cocaine is coming into this country more than the increasing incidence and prevalence of cocaine can support. There is an overabundance of cocaine in the country.

In terms of marketing strategy, a good short-term response to any excess of supply is price reduction coupled with produce enhancement. Crack serves this purpose well, and in so doing, allows it to be readily accessible to you. We can anticipate several future distribution developments. First, in the short term, the oversupply of cocaine is going to continue despite short-term efforts to reduce production and interdict the drug as it comes into the country.

Second, also short term, prices are very likely to continue to drop thus increasing incidence and prevalence so that many other parts of the country will have as serious a problem as we have in New Jersey. However, over the long term we can hope that supply reduction efforts will have an effect, but it will be at that point that an already very bad situation could become worse, and the reason for this lies in the pharmacologic processes and dynamics of treatment, and I will get to those in a minute.

I would want to make an aside comment, and that is that the efforts of your committees, governmental agencies, the media and others to bring the problem of crack to the public view are an important and necessary part of the effort to combat the problem. However, like all such efforts, they also contribute in their own way to its spread. In effect, they must be viewed partially as part of the marketing process and hence must be carefully mediated, more carefully than they are now.

There are kids in north Jersey that don't even know where Washington Heights is, but who are very well aware now of 175th Street.

These market processes don't fully explain the seriousness of the problem, though. Let's take the pharmacologic effects. We already know that the cocaine is a very powerful self-reinforcer, as powerful as any other drug I have seen. For the majority of users that snort cocaine, crack provides an acceptable alternative means of ingestion as opposed to I.V. use.

Incidentally, the effects of crack compared to I.V. use—smoking compared to I.V. use—are fairly minimal. However, the effects of smoking compared to snorting are remarkable. First, you have a vary rapid onset of biological activity. Second, you have a much greater intensity of action, and you also have a shorter duration of the action, and from a marketing point of view, this makes crack almost a perfect product enhancement. It is better; it is cheaper; the customer supply is exhausted more quickly; and, finally the effect is perceived as being more pleasurable.

We have never seen drug that seems to produce such a rapid loss of control as crack does. One of my staff interviewed a 16-year-old girl who, as part of the interview, came back and told me she had completely lost control of her life. She was entirely focused on the drug. The remarkable part of that interview was that he interviewed her on a Friday, and she had first used crack that Monday.

Now, that is the most extreme example that we have seen, but even though we suspected the voracity of what she said, over time and interviewing other users, we believe it. In addition, we believe that a higher proportion of users lose control than with other drugs. The drug that is most frequently studied is alcohol; 10 percent of alcohol users are abusers. We believe the proportion is higher for crack. It is also recognized as being associated with violence.

As a sociologist, I tend to first look for behavioral explanations. However, in this particular instance I believe there is a pharmacologic basis for this as strong as with any other drug with the possible exception of methamphetamine, which I think is probably as strong, but certainly not stronger.

All of these properties affect the treatment dynamics. We have been treating cocaine users for quite a few years now. In 1980 less than 1 out of 25 treatment admissions in New Jersey was for cocaine. Now it is about 1 out of 6. At the same time the proportion of cocaine users entering treatment who smoke rather than snort is increasing.

We haven't yet seen large numbers of crack users entering treatment compared to traditional cocaine users or I.V. heroin users in a system that is geared to treat I.V. heroin as its first concern. Users and their families generally are more reluctant to admit their problems with crack compared with some other drugs. The process of denial is greater for crack than it is in my experience for other drugs, alcohol, heroin, what have you. It appears to take the crack user longer to hit bottom.

Virtually all treatment programs in New Jersey report a large volume of calls about crack from the families, from users, from concerned people, but these are not yet being followed up with substantial admissions to treatment. The ongoing seduction of the drug overrides the temporary concern of the individual over their possible loss of control.

To return for a moment to my previous comments, the combination of the marketing processes and the pharmacologic effects leads to a potentially dangerous scenario. If we can expect a short-term drop in prices and then a future increase in prices, chronic users will hit bottom and a treatment system will see the greatest demand for services. We have also probably seen more violence associated with the drug than we do now.

Chairman **Rangel**. Mr. French, the clock is really working against us. Chairman Rodino needs this room, so I would ask if you could conclude because we do want to hear from Mr. Lawrence before we conclude.

Mr. **French**. All right, 1 more minute, then.

Our treatment problem in New Jersey, and I should say before that, that we strongly emphasize prevention for youth, but the treatment problem in New Jersey is threefold: First, the difficulty of recruiting crack users into treatment; second, the fact that less expensive outpatient treatment processes will probably not be sufficient; and, third and most important, the entire health care system of New Jersey is in the midst of a catastrophe now. It is the worse that this country has seen, and that is AIDS.

Over half of the I.V. drug users in New Jersey are infected with the virus. Over half of the cases of AIDS in New Jersey are I.V. drug users. Our first line of defense is the drug treatment system. I am asked in my function to analyze data, interpret data, and make recommendations, and I say, how can I make a recommendation when it is almost putting me in a position of saying—and I have four children—which ones of those children do you want to die by which means? It is as simple as that.

We are facing an unbelievable crisis and we are in a situation of dramatically reduced funding over the last 5 years, and now we are faced with a new epidemic which in many ways can be considered as severe a strain on the drug treatment system as the AIDS epidemic, and how do we approach trying to solve that? Thank you.

[The statement of Mr. French appears on p. 229.]

Chairman **Rangel**. Thank you, Chief French. Mr. Lawrence.

TESTIMONY OF MALCOLM LAWRENCE, FORMER SPECIAL ASSISTANT FOR INTERNATIONAL NARCOTICS MATTERS, U.S. DEPARTMENT OF STATE

Mr. **Lawrence**. It is an honor for me to appear here at these vital hearings on crack, the newest treacherous drug form. News stories proliferate about the tragic cocaine-induced deaths of Len Bias and Don Rogers. Among the questions raised is the very basic one: why did Bias and Rogers use cocaine? The answer is twofold. They used cocaine because the cocaine was there, and because they really didn't know any better. Obviously, neither one was attempting suicide.

Like Bias, Don Rogers, and millions of other American youngsters are taking cocaine and all kinds of other illegal drugs because the drugs are available and are in fact tolerated by our society.

A major contributing factor to the tolerance of illicit drugs and narcotics in America is that many of our schools are sending out no messages or weak and confusing messages. Since the early 1970's, educators have been brainwashed by permissive pundits and curriculum developers to believe that scare tactics and facts about drugs are counterproductive, and that the solution to the drug abuse problem for students is to use a values clarification approach, apply compassion, give counseling, and at all costs avoid using the word, "don't" when discussing drugs. The fashionable approach in drug education has been to let the children examine all aspects of their feelings, attitudes, values and societal pressures and then let the children make up their own minds as to whether or not to use drugs.

In point of fact, our schools never really did use effective scare tactics or give adequate factual information about the serious effects of drugs on the body, the brain, or the genes. Those who say that scare tactics and facts have failed are usually the ones who make the ridiculous argument that law enforcement has failed, the implication being that we have to give up law enforcement and try something else. As any sensible person in the drug battle knows, we need all the help we can get.

In my 17 years of experience in dealing with the drug problem, I have read much drug curriculum and talked with many parents. I have yet to come across any good, solid, effective education. I have, however, become acquainted with some poor curriculum and have given some examples in my written testimony.

I have reached the conclusion that our wishy-washy approach on the demand side of the drug problem has been a major contributing element to addiction and death among our youth. In a word, our schools are not tough enough. The solution is not more values clarification and situation ethics, but factual instruction backed up by a no-nonsense school policy. The school should get tough and stay tough. Fighting drugs is not a one-shot deal.

I have been asked to comment on the Federal Government's responsibility to encourage greater school participation in antidrug efforts and how this responsibility should be met. I have a recommendation. If we are going to push for more Federal funds for drug education, we need to know much more about what is going on in the schools. We have to determine what should be taught.

As we begin the third decade of drug crisis in America, I believe it is high time we found out precisely what our children are being taught throughout the country, and how school administrators are dealing with the drug problem. Has the values clarification approach taken over completely? Are there some effective programs and policies deserving of adoption and application by schools nationwide?

I therefore urge the House Select Committee on Narcotics Abuse and Control to undertake a study to analyze how the public schools throughout America are in fact dealing with the drug problem. Now there are some 15,500 school districts, and it would, of course, be too costly and time-consuming to find out what each and every one is doing.

However, the select committee would be providing a highly valuable service by surveying at least the 50 State boards of education and taking a sampling of some 200 to 300 local school districts, that is, four to six districts in each State, to obtain a representative cross-section of the following two aspects of drug abuse prevention: First, the thrust of the drug control policies in the schools; and, second, the nature and contents of the drug abuse curriculum. Such a report should be completed no later than the spring of 1987 so that the select committee could provide valuable findings and recommendations for the 1987-88 school year.

I might incidentally mention that NIDA the National Institute on Drug Abuse is looking for exemplary programs. I would not trust this to NIDA. Their track record is not very good over the last 16 years.

I have also been asked to provide comments today on what needs to be done to strengthen school-based drug abuse prevention programs. Since children spend almost one-half of their waking hours, 5 days a week involved in school activities away from home, the schools constitute the most important focal point for the youth of the community and should spearhead the drive against drug abuse. The school system, after all, is a multibillion-dollar infrastructure working for parents and taxpayers. It is there, and the staff is ready and should be prepared to do the job if they know what to say.

The selection of the school system does not in any way imply that they are at fault, or that it is their cause, but merely that they are centrally located and can help the community. Now, I will cut short here by saying that my second recommendation is that each and every school system in the United States should formulate a drug abuse policy statement containing facts and figures about drugs which would serve as a community education document and which would form the basis for the drug education program in the school system. I have given some details as to what I think should be in such a policy statement. I think perhaps the Department of Education could, assume some leadership in finding out what really works, but I think this committee is in a better position to do that than the Department of Education in the current administration. Thank you.

[The statement of Mr. Lawrence appears on p. 234.]

Chairman RANGEL. What handle will we have, Mr. Lawrence, if we are not giving any Federal dollars, and if we know that most of the schools have no drug abuse curriculum, and if the Federal policy is to just get tough, but not to give any programs.

Mr. LAWRENCE. I think there should be a Federal policy, certainly, and I think that just to say that a kid should be thrown out of school is ridiculous, too, as William Bennett has said. I also think it is ridiculous that President Reagan has waited until the sixth year of his term of office to say that he is going to make a personal statement about drug abuse. It is nice to have Nancy Reagan going around saying don't use drugs and have Carlton Turner as her baggage boy, but this is not the President of the United States. I think William Bennett has got to get into the act. He has got to get into the education act and so has NIDA, but both agencies have to get much tougher than they have been.

We have a wishy-washy approach on the demand end. If indeed we are going to spend $50 million in a bill proposed before this

Congress, things should change. I agree the schools should play a role, but it is not whether we should teach it or which grade level we should teach or how much we should teach. It is what we teach, and the wrong message has been going out in my estimation in the last 15 years.

Chairman RANGEL. Father Costello, you have gone out of your way to point out that you are a street priest. But why would you think that where we normally hear from our spiritual leaders on the question of communism, on questions of Israel, on the politics of Central America, certainly on the question of hostages that the church and synagogues have spoken out, and yet the street priests and the nuns are out front on this issue, but we don't seem to find the leaders of the church or of the synagogues reaching out to shake this Congress and say that you rascals down there in Washington should be doing something or that there should be a national policy?

Father COSTELLO. I think that the perception of the clergy, at least in general, just like the comment made earlier this morning about the sports world and the comment was made it is merely a mirror of the rest of the world. I think the perception on the part of the clergy is the same as the rest of the world; that drugs is not really a problem. It doesn't affect us directly in the parish.

My argument, of course, is that it does. If you don't like to get burglarized, and you don't like to have your parishioners mugged, and the quality of life is in issue. As a matter of fact, we started something called the substance abuse ministry training program where we trained over 300 community individuals, as well as clergy, as to strategies that they can use in dealing with the drug problem and implementing programs in their own communities.

It seems to work. Some parishes have implemented programs with hotlines and conferences on substance abuse, but I agree with you. I think there has to be a need to shake the Administration and the Congress to be more involved with this issue because the issue is so widespread.

Chairman RANGEL. Well, like you said, it deals with the quality of life, and certainly that is basically a spiritual issue.

Mr. Guarini.

Mr. GUARINI. Father, acknowledging the fact that there are many facets to approach this problem like law enforcement, interdiction and education, you went on to talk about the breakdown within our society. I imagine if we really got down to the root causes, we would be talking about high unemployment amongst our young people, especially our minority groups.

Father COSTELLO. That's right.

Mr. GUARINI. We are talking about the restlessness of our young people and having a lack of direction, the lack of recreation facilities. We are really getting down into the social programs and what makes a person's mind operate in order to determine how to lick this problem. I mean we have slogans as to how to lick it, about demand side and supply side, and we have typical ways of making speeches, but you reminded me of when we met with His Holiness, Pope John Paul, who indicated that it is a family problem and a sociological problem.

We really must get down to the workings of these people's minds and what is going on inside the structure of the family. So what we really have is the sociological breakdown, the social breakdown, if you will, within our society. I mean it is like an acknowledgement that there is something wrong there. It goes beyond talking about law enforcement, how big your jails are and how much money you are throwing out at the problem. What we are really talking about is what is wrong with our society and what a poor job we are doing in bringing up our young people.

As a young person today views life, he sees the wars out there. He is living in a nuclear age. He sees the split up of his own mother and father and his family. He graduates high school and he sees there are so few jobs available, and 50 percent of the minority youth are unemployed and have no hope of getting a job. I guess these are the areas where people start thinking about how do I find an escape.

An escape comes very easy when you say, hey, take this pill; take this drug. This is a way out.

Father COSTELLO. Congressman Rangel made the comment before about the light at the end of the tunnel, and very often for a lot of these kids see it as an oncoming train because these kids—just the attitude that the adult world has about them from what I pick up—they don't trust adults; adults haven't earned their trust. They have questions about the educational system that doesn't respond to their needs. We have other issues like one-parent families, and I see it as a sociological problem. I see it as a moral problem also.

I also see just a general attitude about kids that people seem to have; that they got themselves in this trouble, so they have to get themselves out, and not that is not the case. The scenario, as I read it and see in the streets and daily experiences, there are an awful lot of people in pain out there, and we have to try to do something to provide alternatives to that pain. Certainly we know it is not drugs. We know it is not alcohol, but what is there?

So a fellow like myself, I started a program not wanting to duplicate what other people were doing, and I find myself in the position that we have thousands of people a year coming to us, and our back is against the wall.

Mr. GUARINI. Do you find that the family breakups and the high divorce rate and the things that are happening where the parents are less attentive to the needs of bringing up their children are contributing factors?

Father COSTELLO. I mean a lot of adults today don't want to have children, or they want to limit the number of children that they have because—I guess it is a sense of selfishness. They just want the husband and wife, and they feel that children will interfere with their lives.

Mr. GUARINI. And the youth comes from school and he sees his parents on drugs, where does he have any big hope?

Father COSTELLO. Yes, that is a big part of it; one-parent families.

Mr. GUARINI. So actually you are really talking about, not the drug problem, you are talking about the breakdown within our own society.

Father COSTELLO. And because drugs are all around and because of the addiction factor——

Mr. GUARINI. It gives them escape.

Father COSTELLO. That's right.

Mr. GUARINI. Thank you.

Chairman MILLER [presiding]. Father Costello and Mr. French, it doesn't appear that this problem is very different than other problems that are confronting young people in our society. This isn't something where we are waiting for a magic formula to tell us how to deal with it. If I look at the community which I represent and the communities I have visited with the Select Committee on Children, Youth, and Families there is an incredible potential infrastructure in place to deal with most of these problems, whether it is teenage pregnancy or the hungry or homeless people or drug addiction or runaways, what have you, but that infrastructure is totally inadequate.

Even the best design systems that I have looked at, that do a marvelous job with the people that they treat, only address 15 or 20 percent of the problem in a good year, and these haven't been good years for social service delivery systems. And, you know, when I start looking at some of the statistics in terms of your experience and the numbers of people that you have addressed, I don't want this committee to get the notion that there is nothing going on at the local level.

It is like the law enforcement side. Cops every day are working streets and neighborhoods, but we keep moving them from one neighborhood to another, depending up the political pressure. Everybody is beating the drum now to get involved along the California/Mexican border, by taking all the people that were working in Florida and move them into California or Arizona. Well, you don't have to be a brilliant drug dealer to figure out where you might go next.

Everything today has suggested that this administration didn't want the Federal Government to really be competing with the private efforts.and the local efforts. I don't get any notion when I look at the figures, Mr. French, that you think in New Jersey that you are going to dry up the people that need services here through competition. I talked to a person 3 weeks ago who is working with AIDS in New Jersey, in another hearing we had.

There is no competition for his clients, and he is being swamped. I just wondered to what extent, as you look at the private sector and the public sector, we are dealing with a system that has broken down under the demand.

Mr. FRENCH. In New Jersey, the drug treatment system is about to break down. Drug counselors are going into their offices at lunch time and shutting the door and crying because they are watching their clients die. I haven't been involved in the drug treatment system myself for almost 10 years, but I now avoid, when I am talking with people who used to be my coworkers asking them who has died of AIDS recently. I don't want to hear it anymore.

Chairman MILLER. Your testimony also suggests that given the crack use and what may change in drug marketing that these children are going to show up in our mental health system as well.

Mr. FRENCH. Of course they are. They are going to show up in the drug treatment system, and they are going to show up in the mental health system, of course, and the system right now has had such drastic funding reductions over the last 6 years that we are just not going to be able to cope with it. It is the worse situation I have seen in my life, and I have been involved longer than either one of these gentlemen in the drug field.

Chairman **Miller**. Father Costello.

Father **Costello**. I would just like to say that it is very frustrating. You know, when I have a parent or I have an adult who says to me, "Father, I want help. I have been doing drugs for years. I want to get out of this hole," and we have a lot of leverage because we have so many clients who come to us and the other rehabilitation programs are more responsive and they usually will help me to get an individual in faster.

Well, let me tell you, Mr. Miller, I started my own residential program over 1½ years ago. I have a 3-month waiting list. I can't even get into my own program, so that the fact of the matter is, as Mr. French says, they are banging down our doors and we are really desperate.

The other part of that, of course, is the law is doing their job, and they are arresting them, and we are putting them in jail. So it is very frustrating. What is the message, and the message is a double message certainly, because we are at our wit's end.

In New York City we have over 50 percent of the drug problem. We have tried to get additional funding. We have had 40 percent cutbacks since 1980 to New York State services. As a matter of fact, I wrote down the statistic that the cities and States in fighting this war, New York City and State combined, match the total Federal response to the drug crisis dollar for dollar. The New York City Police Department spent twice as much as the Federal Drug Enforcement Administration, and the city's five district attorneys spent seven times more than the U.S. Justice Department's Criminal Division, and the so-called war against drug abuse.

Chairman **Miller**. Well, that is the challenge of this hearing for policymakers.

I want to thank you very much for taking your time to come share your information with us. You don't have to be a genius to figure out what is going on in this town. We are struggling for a response. I just hope that we do it in some way that will help people at the local level like yourselves that struggle with it from day to day. We don't have to create a terribly new system. We have to put some resources into the existing system so that people have some help.

Thank you very much for your time and your trouble.

[Whereupon, at 3 p.m., the hearing was adjourned subject to the call of the Chair.]

[The material previously referred to follows:]

STATEMENT OF THE

HONORABLE CHARLES B. RANGEL

CHAIRMAN

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

JULY 15, 1986

GOOD MORNING LADIES AND GENTLEMEN.

TODAY THE SELECT COMMITTEE ON NARCOTICS JOINS WITH THE SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES IN EXAMINING THE ABUSE OF "CRACK" COCAINE THAT IS RAPIDLY SPREADING THROUGHOUT THE COUNTRY.

"CRACK" IS THE STREET NAME GIVEN TO FREEBASE COCAINE MADE BY HEATING COCAINE HYDROCHLORIDE WITH BAKING SODA AND WATER. THE TERM "CRACK" REFERS TO THE CRACKLING SOUND MADE WHEN THE DRUG IS SMOKED.

TODAY WE WILL EXAMINE THE EXTENT OF CRACK USE IN THE UNITED STATES, THE SERIOUS HEALTH CONSEQUENCES IT PRESENTS TO THOSE WHO ABUSE IT, AND THE LAW ENFORCEMENT PROBLEMS CRACK IS CREATING.

IN THE PAST MONTH WE HAVE SEEN TRAGIC REMINDERS THAT COCAINE KILLS. THE DEATHS OF LEN BIAS AND DON ROGERS, TWO TALENTED YOUNG ATHLETES, ARE SHOCKING EXAMPLES THAT MILLIONS OF AMERICANS ARE VULNERABLE TO THE DANGERS OF COCAINE.

TODAY THE ABUSE OF COCAINE TAKES ON MORE DANGEROUS ASPECTS WITH THE SUDDEN POPULARITY OF CRACK.

ALMOST A YEAR AGO TO THIS DAY, THE SELECT COMMITTEE ON NARCOTICS HELD A HEARING ON "COCAINE ABUSE AND THE FEDERAL RESPONSE". THIS HEARING DRAMATICALLY DOCUMENTED THE RAPID EXPANSION OF COCAINE ABUSE IN THE UNITED STATES SINCE 1980 AND

THE LACK OF EFFECTIVE FEDERAL PROGRAMS TO DEAL WITH THIS SERIOUS DRUG ABUSE PROBLEM.

AT THE TIME OF OUR HEARING LAST YEAR, CRACK WAS VIRTUALLY UNHEARD OF. OVER THE PAST YEAR, HOWEVER, THE CRACK COCAINE CRISIS HAS EXPLODED. IN PRACTICALLY EVERY NEWSPAPER TODAY, WE READ OF STORIES OF UNFORTUNATE INDIVIDUALS WHO HAVE FALLEN VICTIM TO CRACK, CAUSING INJURY TO THEMSELVES AND OTHERS.

CRACK IS CHEAP AND READILY AVAILABLE. IT ALSO DELIVERS A POWERFUL HIGH THAT IS MUCH SOUGHT AFTER BY USERS. THE DANGER OF THIS DRUG IS THAT USERS CAN BECOME ADDICTED TO CRACK A SHORT TIME AFTER BEING INTRODUCED TO IT. THIS HAS SERIOUS IMPLICATIONS FOR THE HEALTH AND WELFARE OF OUR COUNTRY, PARTICULARLY OUR YOUTH, WHEN ONE CONSIDERS THE ALREADY SERIOUS EXTENT OF COCAINE ABUSE IN THE UNITED STATES.

APPROXIMATELY 5 MILLION AMERICANS ARE CURRENT USERS OF COCAINE.—COCAINE RELATED DEATHS NATIONALLY HAVE RISEN FROM 195 IN 1981 TO 600 IN 1985. COCAINE RELATED EMERGENCY ROOM MENTIONS GREW FROM 3,296 TO 9,946 DURING THE SAME PERIOD.

ACCORDING TO THE 1985 HIGH SCHOOL SENIOR SURVEY CONDUCTED BY THE NATIONAL INSTITUTE ON DRUG ABUSE (NIDA), LAST YEAR'S HIGH SCHOOL GRADUATING CLASS USED COCAINE AT UNPRECEDENTED LEVELS: 17 PERCENT HAD TRIED COCAINE, 13 PERCENT HAD USED COCAINE IN THE

LAST YEAR, AND 7 PERCENT IN THE LAST MONTH. A SURVEY OF COLLEGE STUDENTS CONDUCTED BY NIDA FOUND THAT NEARLY ONE-THIRD WILL TRY COCAINE BY THE TIME THEY GRADUATE AND NEARLY 40 PERCENT OF ALL HIGH SCHOOL GRADUATES WILL TRY COCAINE BY AGE 27.

IN SHORT, COCAINE IS THREATENING THE VITALITY OF THE GENERATION OF AMERICANS WE ARE COUNTING ON TO LEAD US INTO THE 21ST CENTURY.

OUR HEARING TODAY WILL EXAMINE THE CRACK EPIDEMIC AS PART OF THE OVERALL COCAINE ABUSE PROBLEM IN AMERICA. THIS PROBLEM WILL CONTINUE AS LONG AS THE CULTIVATION OF ILLICIT COCA CONTINUES UNABATED IN THE PRODUCING COUNTRIES OF SOUTH AMERICA, AND AS LONG AS THE ADMINISTRATION AND STATE DEPARTMENT VIEW THE INTERNATIONAL DRUG PROBLEM AS "BUSINESS AS USUAL". ONLY WHEN WE GIVE THE DRUG PROBLEM THE FOREIGN POLICY PRIORITY IT DESERVES WILL WE EVER BEGIN TO GET A HANDLE ON THE COCAINE CRISIS SWEEPING OUR NATION.

THROUGH OUR WITNESSES TODAY WE WILL INQUIRE INTO THE EXTENT OF CRACK COCAINE ABUSE IN THE UNITED STATES, THE PROBLEMS CRACK IS CREATING FOR LAW ENFORCEMENT, DRUG ABUSE TREATMENT AND PREVENTION SPECIALISTS, USERS AND PARENTS, AND WHAT OUR FEDERAL DRUG ABUSE AGENCIES ARE DOING TO ADDRESS THIS PROBLEM.

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OPENING STATEMENT
GEORGE MILLER
CHAIRMAN
"THE CRACK COCAINE CRISIS"
July 15, 1986

The Select Committee on Children, Youth and Families is responsible to Congress for raising those issues which most seriously threaten the lives of our children.

That is why, together with Chairman Rangel and his Select Committee on Narcotics Abuse and Control, I have called today's hearing on the newest killer drug -- crack. In our view, exposing the serious peril to our youngsters posed by this drug is a matter of urgency.

Today, we will hear from a young person who was addicted to crack, and from her mother on how crack placed severe strains on their family.

We will look at what crack is, why it is spreading so rapidly throughout the country, and what effects it has on youngsters.

We will hear from care-givers, law-enforcement officers, and the highest officials of the U.S. government charged with preventing drug abuse.

We are pleased as well to hear from respected athletes who have taken an active role educating young people about the hazards of drug use.

We have heard that the White House is launching an initiative in drug abuse prevention. We wanted to learn more about it so we could join forces in getting the message across. Unfortunately, they declined our invitation.

And we would like to have heard from the Department of Education, because we believe schools can and must play a central role in the war against drug use among children. Unfortunately, they too declined to appear today.

This extremely addictive form of cocaine wreaks havoc on the mind and body, stripping its users of their health, their finances, their sanity, and even their lives.

In a very short period of time, we have seen sharp increases in crack-related alcohol abuse, suicides, automobile accidents, violence, crime, and deaths.

As a result, this nation has a crisis on its hands.

If we are to help those already in the grip of crack addiction and to prevent it from claiming the lives of thousands more youngsters, we must be aware of the dangers of crack and be prepared to take drastic measures to curb its use.

It is my hope that the testimony we hear today will quickly lead to direct action. Policymakers, law enforcement officers, educators, physicians, and parents must come together to put an end to the needless suffering and heartache caused by crack addiction.

THE HON. PETER W. RODINO, JR.

CHAIRMAN OF THE HOUSE JUDICIARY COMMITTEE
AND
RANKING MEMBER OF THE SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

STATEMENT ON "CRACK" AND AMERICAN YOUTH

HEARINGS HELD JOINTLY BY
THE SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL
AND
THE SELECT COMMITTEE ON CHILDREN, YOUTH AND FAMILIES
JULY 15, 1986

I WANT TO THANK THE CHAIRMEN OF THE TWO SELECT COMMITTEES FOR HOLDING THESE HEARINGS ON THIS CRITICAL NATIONAL ISSUE -- AND I WANT TO WELCOME THE DRUG ENFORCEMENT OFFICERS AND EXPERTS WHO WILL BE TESTIFYING TODAY.

WITH THE RECENT COCAINE-RELATED DEATHS OF STAR ATHLETES LEN BIAS AND DON ROGERS, OUR NATION HAS ONCE AGAIN LEARNED THE HARD WAY ABOUT THE DANGERS OF OUR NATIONAL DRUG EPIDEMIC. THE LESSON IS CLEAR: DRUG ABUSE CAN HIT ANYONE, NO MATTER HOW PROMISING AND SUCCESSFUL. IT ALSO TELLS US ANOTHER UNFORTUNATE FACT -- THAT OUR NATION IS LOSING THE WAR ON DRUGS.

AS THESE HEARINGS WILL SHOW, A NEW DRUG -- "CRACK" -- IS THREATENING TO OVERRUN WHATEVER LINES OF DEFENSE WE HAVE LEFT AGAINST DRUG ABUSE. "CRACK," A CHEAP AND HIGHLY ADDICTIVE DERIVATIVE OF COCAINE, IS ON THE VERGE OF BECOMING THE NEW PIED PIPER OF AMERICAN YOUTH. WE'VE GOT TO STOP IT.

ALTHOUGH "CRACK" IS NEW TO THE DRUG CULTURE, STUDIES INDICATE THAT IT'S ALREADY BEEN USED BY 1 MILLION AMERICANS IN

AT LEAST 25 STATES. AND IT'S SPREADING RAPIDLY. ONE LOS ANGELES DRUG TREATMENT CENTER REPORTS THAT WHILE LESS THAN A YEAR AGO, IT HAD NO "CRACK" ADDICTS -- "CRACK" ADDICTS TODAY ACCOUNT FOR 80 PERCENT OF ITS CLIENTS. ONCE SOMEONE TRIES IT, THE USER SEEMS TO CRAVE THE NEXT HIT.

CONSIDERING THAT IT COSTS AS LITTLE AS $10 A HIT -- THAT IT IS ALMOST IMMEDIATELY ADDICTIVE -- AND THAT IT CAN BE OBTAINED ON JUST ABOUT ANY STREET CORNER -- "CRACK" HAS BECOME, AS ONE DRUG ABUSE EXPERT PUT IT, "THE DEALER'S DREAM AND THE USER'S NIGHTMARE."

"CRACK" USE APPEARS TO CROSS ALL RACIAL, SOCIAL AND ECONOMIC BOUNDARIES. BUT BECAUSE OF ITS LOW COST AND EASY AVAILABILITY, IT HAS HIT YOUNG PEOPLE IN INNER CITIES PARTICULARLY HARD. MANY HAVE TURNED TO CRIME AND PROSTITUTION TO SUPPORT THEIR HABITS. OTHERS HAVE BECOME ACCOMPLICES IN THE "CRACK" EPIDEMIC, RUNNING WHAT ARE KNOWN AS "CRACK" HOUSES FOR THE SALE AND DISPENSING OF THE DRUG. A POLICE DETECTIVE IN LOS ANGELES -- WHICH IS A CENTER FOR "CRACK" USE -- OBSERVED THAT THE "CRACK" BUSINESS HAS BECOME THE LARGEST SINGLE EMPLOYER OF INNER CITY YOUTH.

THE "CRACK" EPIDEMIC IS A FRIGHTENING SYMPTOM OF OUR LARGER FAILURE TO CURB OUR NATION'S DRUG HABIT. TAKE COCAINE, "CRACK'S" PARENT DRUG, AS AN EXAMPLE. SINCE 1980 THE AMOUNT OF COCAINE SMUGGLED INTO THIS COUNTRY HAS INCREASED SIX-FOLD. COCAINE USE AMONG HIGH SCHOOL SENIORS HAS DOUBLED IN THE LAST TEN YEARS -- TO THE POINT THAT NEARLY 1 OUT OF 5 HAS TAKEN IT, AND 1 OUT OF 2 KNOWS HOW TO GET IT.

WE ARE AT THIS CRISIS POINT IN PART BECAUSE OF A FAILURE TO DEVELOP A NATIONAL STRATEGY ON HOW TO COMBAT DRUGS. FOR YEARS WE

HAVE TRIED A NUMBER OF DIFFERENT APPROACHES USING VARIOUS AGENCIES OF GOVERNMENT. TODAY OUR DRUG ENFORCEMENT AND TREATMENT RESOURCES ARE STRETCHED TO THEIR LIMITS. BECAUSE OF THIS MISMANAGEMENT AND LACK OF RESOLVE, I'M AFRAID THAT TIME IS RUNNING OUT. WHAT WE NEED -- RIGHT NOW -- IS TO POOL THE BEST MINDS AND RESOURCES OF OUR NATION TO COME UP WITH A COMPREHENSIVE APPROACH TO OUR DRUG PROBLEM.

THAT IS WHY I -- ALONG WITH CHAIRMAN RANGEL AND REPRESENTATIVES HUGHES, GUARINI AND GILMAN -- HAVE PROPOSED A RESOLUTION CALLING ON THE PRESIDENT TO CONVENE A WHITE HOUSE CONFERENCE ON NARCOTICS ABUSE AND CONTROL FOR THE PURPOSE OF DEVELOPING A NATIONAL STRATEGY ON DRUGS. BECAUSE OF THE URGENCY OF THIS ISSUE, THE JUDICIARY SUBCOMMITTEE ON CRIME WILL BE MARKING UP THE BILL NEXT WEEK.

THE REASON WE ARE CALLING FOR A WHITE HOUSE CONFERENCE IS THAT WE BELIEVE THE CRISIS DEMANDS PRESIDENTIAL LEADERSHIP. WE HAVE WRITTEN TO THE PRESIDENT ASKING FOR HIS SUPPORT FOR A WHITE HOUSE CONFERENCE, BUT SO FAR HE HAS MADE NO COMMITMENT. I AM GRATIFIED BY RECENT REPORTS THAT THE PRESIDENT INTENDS TO SPEAK OUT PUBLICLY AGAINST DRUG ABUSE. BUT SPEECHES, HOWEVER WELCOME, ARE NOT ENOUGH. WHAT WE NEED IS A COORDINATED AND ENERGETIC STRATEGY AGAINST DRUGS.

WE MUST TREAT DRUGS AS A NATIONAL SECURITY ISSUE -- AS A THREAT TO OUR FREEDOMS -- AND WE MUST MAKE OUR NATION'S RESOURCES AS AVAILABLE FOR THE WAR ON DRUGS AS FOR NATIONAL DEFENSE. DRUGS ARE AN INSIDIOUS ENEMY, AND WE MUST DO WHATEVER IT TAKES TO COMBAT THEM.

THANK YOU.

HOUSE OF REPRESENTATIVES, WASHINGTON, D.C.

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"CRACK" HEARING
JULY 15, 1986
STATEMENT OF
HON. HAMILTON FISH
(R-NY)

THIS MORNING'S HEARING ON CRACK AND ITS WIDESPREAD USE AMONGST OUR YOUTH IS NOT ONLY TIMELY BUT OF CRITICAL IMPORTANCE. NINE MONTHS AGO ADDICTION TO CRACK WAS VIRTUALLY UNHEARD OF --- NOW YOU CAN NOT PICK UP A NEWSPAPER WITHOUT HEARING THAT CRACK IS AN EPIDEMIC, A PLAGUE THAT IS SWEEPING THE COUNTRY.

CONSIDER THESE FACTS:

COCAINE CLAIMED THE LIVES OF 563 PEOPLE IN 25 MAJOR U.S. CITIES LAST YEAR, NEARLY THREE TIMES THE NUMBER OF COCAINE-RELATED DEATHS IN THOSE CITIES IN 1981, ACCORDING TO THE NATIONAL INSTITUTE ON DRUG ABUSE.

In New York City, cocaine was listed as the primary cause of 137 deaths in 1985, compared with only 7 in 1983, as reported by the New York State Division of Substance Abuse Services. In 1985 doctors treated 3,000 people for overdoses in New York City alone.

A recent survey of high school and college students conducted by the Institute for Social Research at the University of Michigan reported that 30% of all college students will have used drugs at least once by the end of their fourth year in college. The report stated that "clearly this nation's high school students and other young adults still show a level of involvement with illicit drugs which is greater than can be found in any other industrialized nation in the world."

Today's hearing is an investigation into the "crack" problem. Because "crack" is both affordable and highly potent, our investigation will focus on the potential impact of "crack" on our nation's youth. My hope is that today's investigation will shed some light on what the Federal government as well as local state governments are doing to respond to the growing problem of "crack" addiction. In addition, we hope to learn what prevention and treatment approaches work, to stem the apparent explosion of crack use.

I look forward to all the testimony before us today.

U. S. HOUSE OF REPRESENTATIVES

STATEMENT OF

HONORABLE WALTER E. FAUNTROY
(D., D.C.)

BEFORE THE

JOINT HEARING

OF THE

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL
AND
SELECT COMMITTEE ON CHILDREN, YOUTH AND FAMILIES

ON THE

"GROWING PROBLEM OF 'CRACK' COCAINE"

JULY 15, 1986 2141 RAYBURN HOB

9:30 A.M.

MR. CHAIRMAN, OUR HEARING THIS MORNING IS A MOST TIMELY AND APPROPRIATE EMPHASIS UPON A NEW THREAT THAT IS EMERGING IN THE MIDST OF OUR ALREADY ALARMING INCIDENCE OF DRUG ABUSE AND TRAFFICKING.

THE SPECTRE OF A NEW FORM OF COCAINE--A CONCENTRATION OF COCAINE SO LETHAL AND SO INTENSE THAT THE USE CAN SEAR THE SENSES OF AN INDIVIDUAL'S BRAIN SO CHRONICALLY AS TO LEAVE THAT PERSON HOPELESSLY ENSLAVED AND DESPERATE FOR THE NEXT, IMMEDIATE DOSE. THAT AWFUL SPECTRE OF A NEW CONCENTRATION OF COCAINE CALLED "CRACK" OR "ROCK" WHICH IS RACING THROUGH OUR COMMUNITIES FROM ONE COAST TO THE OTHER IS LIKE THE PLAGUE. IN FACT, IT SHOULD BE CALLED "THE PLAGUE"--ITS IMPACT IS SO TERRIBLE AND SO CONSUMING.

EVERY AREA OF OUR LIFE, EVERY INSTITUTION OF OUR SOCIETY IS BEING AFFECTED BY THE TRAGEDY AND HIGH COST OF DRUG ABUSE. FROM THE DANGERS OF MONEY LAUNDERING AND THE HIGH COST OF MEDICAL EXPENSES FOR TREATMENT OF THE AFFLICTED, TO THE TRAGEDY OF USEFUL LIVES RENDERED USELESS, THE CRISIS OF DRUG ABUSE IS EVER WIDENING AND GROWING. ONE OF THE MOST RECENT, PAINFUL EXAMPLES OF THE COST IN WASTED HUMAN LIVES AND THE WANTON DESTRUCTION OF PUBLIC PROPERTY IS THE "FIRING OF OCCOQUAN I AND II AT LORTON" BY INMATES WHO TOOK ADVANTAGE OF A BAD SITUATION AND EXPLOITED IT.

THE PLIGHT OF OUR NATION'S PRISONS IS GREAT--CLOGGED AS THEY ARE WITH INMATES SENTENCED FOR DRUG-RELATED OFFENSES. IN THE DISTRICT

OF COLUMBIA ALONE, THE DRUG-RELATED INCARCERATION PERCENTAGE IS AT LEAST 60%. THIS MEANS THAT THE GROWING PRISON POPULATION IS IN DIRECT PROPORTION TO THE GROWING DRUG ABUSE AND TRAFFICKING PROBLEMS AMONG OUR CITIZENS.

ANOTHER SET OF FIGURES THAT IS AN IMPORTANT SYMPTOM OF THE GROWING PROBLEM AFFECTING OUR PRISON POPULATIONS HAS BEEN COMPILED BY THE DIRECTOR OF PRETRIAL SERVICES OF THE DISTRICT OF COLUMBIA COURTS, MR. JOHN CARVER. URINE ANALYSIS SAMPLING WITHIN 2-12 HOURS AFTER ARREST INDICATES THAT 65% OF THE PERSONS ARRESTED AT THE PRESENT TIME HAVE SOME FORM OF ILLEGAL DRUG IN THEIR SYSTEMS. BUT ANOTHER SET OF RECORDS KEPT BY PRETRIAL SERVICES HAS A DIRECT MESSAGE FOR THIS HEARING. THERE IS A TREMENDOUS INCREASE IN COCAINE USEAGE REVEALED IN THESE DRUG URINE ANALYSIS TESTS. TWO YEARS AGO 14% OF THOSE ARRESTED TESTED FOR COCAINE; WITH AN INCREASE IN EACH MONTH SINCE THEN OF ABOUT 2%, NOW 35-36% OF THOSE ARRESTED TEST FOR COCAINE ABUSE.

THE COST OF DRUG ABUSE IS REACHING FAR BEYOND THE TRAGIC LOSS OF A YOUNG PERSON TO A USEFUL LIFE IN OUR SOCIETY, SAD AS THAT IS. IT IS NOW A CRISIS THAT IS ENGULFING MAJOR INSTITUTIONS OF OUR SOCIETY WITH FINANCIAL COSTS THAT VERGE ON BANKRUPTING THE PUBLIC TAX COFFERS. OUR GROWING PRISON POPULATION IS ONE SUCH INSTITUTION IN CRISIS. AS I INDICATED, THE RECENT FIRING OF BUILDINGS AT OCCOQUAN I AND II AT THE LORTON PRISON FACILITIES IS DIRECTLY RELATED TO THE INCREASED DRUG ARREST AND PROSECUTIONS NECESSARY IN OUR COMMUNITIES. BLAME FOR THOSE FIRINGS FALLS IN MANY PLACES.

- The residents of the Lorton prison who took lawless advantage of the situation and set fires that destroyed the buildings at a time when space was so crucial, should be prosecuted to the fullest extent of the law.

- These same residents of Lorton should have been concentrating on rehabilitating their lives and instead created more expense and difficulty for their communities and their local government and brought further disgrace upon themselves.

- The media shares a great deal of the responsibility for the wasted tax dollar and the destruction of needed dormitories, by irresponsibly reporting inflammatory and suggestive material, inducing as it did, a self-fulfilling behavior and a "copy-cat" syndrome at its worst.

- Unlike any other jurisdiction, the District of Columbia is burdened with a special, land-locked status. Residential areas and green spaces are constantly being squeezed unfairly by encroaching institutions, and there is no place to expand needed municipal developments. The Federal Government, until recently, has always assumed a supportive role in tackling the problem of incarcerating those who commit crimes in the Nation's capital. Yet, at a time when adult arrests have increased by nearly 25 percent in the past 7 years, when prosecutions have increased by nearly 40% and convictions have increased more than 80% during that same period, and at a time when the number of inmates in District facilities has multiplied by more

> than 60% in 7 years, the Federal Government has in the recent past refused to accept any new District of Columbia prisoners in Federal facilities. The Lorton firings have caused the Federal Government to accept approximately 300 prisoners, but much more needs to be done.

DRUGS--and now "CRACK"--are indeed the source of a threat to all civilized society and each of us must accept 100% of the responsibilit for eliminating this threat in our midst. It's growing menace will require all our resources to win this terrible struggle.

It is my hope that the HEARINGS this morning on the appalling consequences of "crack" will give us some ways to do our share--each of us--to regain the safety and productivity of a healthy, useful society.

# # # #

MICHAEL G. OXLEY
[illegible] OHIO

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SELECT COMMITTEE ON
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Statement of the Honorable Michael G. Oxley of Ohio
Before the Select Committee on Narcotics Abuse and Control
Hearing on "Crack" Cocaine

July 15, 1986

THANK YOU, CHAIRMAN RANGEL.

I AM ANXIOUS TO HEAR OUR WITNESSES' TESTIMONY, SO I WILL NOT TAKE UP TOO MUCH TIME. I WOULD LIKE TO WELCOME THE MEMBERS OF THE SELECT COMMITTEE ON CHILDREN, YOUTH AND FAMILIES WHO ARE PARTICIPATING IN THIS HEARING WITH US, AND TO THANK THE REPRESENTATIVES OF THE VARIOUS FEDERAL AGENCIES REPRESENTED HERE TODAY, AS WELL AS THE LAW ENFORCEMENT OFFICIALS AND TREATMENT SPECIALISTS, FOR JOINING US.

THE PURPOSE OF THIS MORNING'S HEARING IS TO TAKE A LOOK AT THE GROWING PROBLEM OF "CRACK" COCAINE. IT IS A TIMELY TOPIC. ONE CAN HARDLY PICK UP A NEWSPAPER THESE DAYS WITHOUT READING OF ANOTHER YOUNG VICTIM OF CRACK.

CRACK IS NOT A NEW DRUG. WHAT IS NEW IS THE WIDESPREAD SALE OF THIS SUBSTANCE ON THE STREET. CRACK IS A VICIOUS DRUG THAT IS SWEEPING ACROSS OUR NATION AT BREAKNECK SPEED. IT WAS FIRST BROUGHT TO THE ATTENTION OF OUR COMMITTEE AT A DEA BRIEFING ONLY NINE MONTHS AGO. SINCE THEN, IT HAS BECOME THE MAJOR TOPIC OF DISCUSSION ON THE NATIONAL COCAINE HOTLINE.

CRACK IS SO DANGEROUS THAT EVEN HEROIN ADDICTS ARE AFRAID OF IT. YET BECAUSE IT IS AFFORDABLE, IT IS APPEALING, ESPECIALLY TO VULNERABLE YOUNG PEOPLE.

I FEAR THE CONSEQUENCES OF CRACK ABUSE. BUT I AM HOPEFUL THAT WE WILL BE ABLE TO PREVENT WHAT IS ALREADY CLOSE TO AN EPIDEMIC. I LOOK FORWARD TO SHARING IN THE KNOWLEDGE AND EXPERTISE OF TODAY'S WITNESSES.

THANK YOU.

OPENING REMARKS OF CONGRESSMAN MEL LEVINE
JOINT HEARING OF THE SELECT COMMITTEES ON
NARCOTICS ABUSE AND CONTROL, AND
CHILDREN, YOUTH AND FAMILIES
JULY 15, 1986

WE ARE HERE TO EXAMINE THE PROBLEM OF CRACK, OR ROCK COCAINE, AS IT IS KNOWN MORE POPULARLY IN MY DISTRICT.

I AM ESPECIALLY PLEASED TO HAVE THE OPPORTUNITY TO PARTICIPATE IN THIS JOINT HEARING WITH THE SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES. CRACK IS A PARTICULARLY INSIDIOUS DRUG. IT IS INTENSELY ADDICTIVE AND LIFE THREATENING. THE TRAGIC DEATHS OF LEN BIAS AND DON ROGERS GRAPHICALLY ILLUSTRATED THE DANGERS POSED BY COCAINE USE. CRACK MAY WELL BE THE MOST THREATENING FORM OF COCAINE ABUSE.

THE HORROR OF CRACK ADDICTION TRANSCENDS THE DRUG PROBLEMS WE HAVE SEEN SO FAR. CRACK ADDICTS ITS VICTIMS MORE QUICKLY, ENTRAPPING YOUNG AND OLD USERS WITH MINIMAL EXPOSURE. CRACK ADDICTION OFTEN LEADS TO VIOLENT AND CRIMINAL BEHAVIOR TO SUPPORT THE HABIT. AND IN RECENT WEEKS CRACK HAS BEEN SHOWN TO BE A VERY DEADLY DRUG.

CRACK HAS BEEN AVAILABLE IN SOUTHERN CALIFORNIA FOR ABOUT FIVE YEARS, RESULTING IN THE INCREASING CRIME AND MEDICAL EMERGENCIES BEING RECOGNIZED MORE RECENTLY IN OTHER PARTS OF THE COUNTRY. IN PARTS OF LOS ANGELES DRUG BUYERS CAN PURCHASE CRACK WITHOUT EVEN LEAVING THEIR CARS. IT WAS RECENTLY REPORTED IN THE LOS ANGELES TIMES THAT STREET DEALERS IN MY AREA WERE USING A STOLEN STOP SIGN TO FLAG DOWN CARS TO MAKE ADDITIONAL DRUG SALES. IN ANOTHER AREA OF LOS ANGLES, DEALERS SET UP A TRASH CAN SLALOM COURSE TO SLOW TRAFFIC

AND PROVIDE MORE OPPORTUNITIES FOR DRUG SALES.

LOCAL POLICE ARE HAVING A PARTICULARLY DIFFICULT TIME DEALING WITH THE CRACK EXPLOSION. WHEN THEY ARE SUCCESSFUL IN CLOSING DOWN THE DRUG TRAFFIC IN ONE AREA OF TOWN, THE DRUG MARKET SIMPLY MOVES AND OVERWHELMS ANOTHER NEIGHBORHOOD.

THE VICTIMIZATION PRODUCED BY CRACK ADDICTION IS INFINITE. DESPERATE ADDICTS WILL STEAL, SELL THEIR POSSESSIONS, AND EVEN SELL THEMSELVES TO BUY MORE CRACK. AND AFTER THE EUPHORIC HIGH, A CRUSHING DEPRESSION SETS IN -- RESULTING IN FURTHER CRAVING FOR CRACK. PARTICULARLY DISTURBING ARE STUDIES WHICH TIE THE ALARMING INCREASE IN YOUTH SUICIDES, IN LARGE MEASURE, TO DRUG ABUSE.

THIS DEADLY MENACE MUST BE HALTED. THE WAR ON COCAINE MUST BE WAGED AND WON. THE WALL STREET JOURNAL NOTES THAT THE COCAINE INDUSTRY IS PURE CAPITALISM, PURE SUPPLY AND DEMAND. WE MUST ATTACK BOTH ENDS OF THIS GRISLY EQUATION, BOTH HALTING THE SUPPLIES, AND ENDING THE DEMAND.

TO ACHIEVE THIS, ALL LEVELS OF SOCIETY ARE GOING TO HAVE TO WORK TOGETHER TO ERADICATE DRUG ABUSE. THERE IS AN EPIDEMIC RUNNING RAMPART IN OUR SCHOOLS NOW -- DRUG ABUSE. THIS EPIDEMIC WILL KILL SCHOOL CHILDREN AND RUIN LIVES. WE MUST BEGIN TODAY TO FIND EFFECTIVE WAYS TO PUT AN END TO THE GROWING USE OF DRUGS AMONG OUR YOUNG PEOPLE. THERE IS NO GREATER THREAT TO THE FUTURE OF OUR NATION THAN THE PROSPECT OF A NEW GENERATION WHOSE LIVES HAVE BEEN DAMAGED BY DRUG ABUSE.

I WANT TO WELCOME OUR WITNESSES TODAY. I LOOK FORWARD TO HEARING WHAT YOU ARE DOING, AND WHAT WE SHOULD DO, TO END THIS TERRIBLE SCOURGE.

THANK YOU MR. CHAIRMAN.

OFF SEASON

athletes working in the public interest

PREPARED STATEMENT OF

KEVIN GREVEY

I appreciate the opportunity to testify before the House Select Committee on Narcotics Abuse and Control and the House committee on Children, Youth and Families regarding drug abuse and associated problems, especially cocaine in its various popular forms such as crack, crank and black rock.

I am Kevin Grevey. I have just completed 10 years in the National Basketball Association. Since my retirement this past season, I have decided, through my role as President of Off Season, Inc., to concentrate on activities involving professional athletes to help address public service needs. Off Season is a Washington D.C. based non-profit corporation established in 1977 for this purpose. Our present emphasis is to help combat drug abuse, both among athletes and in society at large, especially among youth.

Drug use among teenagers has reached alarming proportions, particularly with crack and other forms of cocaine which have become readily available and relatively inexpensive. In my travels across the country performing basketball clinics and workshops, I've had the opportunity to work with many young

918 sixteenth street nw washington dc 20006 area 202 466·3030

athletes in their schools. I am saddened to tell you how I had to change the focus of my instruction over the years from the fundamentals of basketball -- shooting, passing, dribbling and rebounding -- to the hazards of using drugs. In my opinion, administrators, teachers and coaches are now faced with their greatest task ever, and that's educating students about drugs.

Crack and other forms of cocaine are not just ruining young minds and athletic careers. They are taking lives at an alarming rate.

Lately, with the recent cocaine-induced deaths of Len Bias and Don Rogers, a lot of attention has been drawn to drug abuse in professional and amateur sports. No question about it, there is a serious problem. I saw teammates who had trouble performing because of cocaine use, and some ultimately destroyed their careers. The sad thing is that many of these athletes' cocaine problems didn't start with the newfound success and wealth of professional sports, like most people want to believe, nor did they start in their college years. For some, their exposure to drugs came as early in their lives as junior high school or even grade school. Drug abuse today is a problem that has no boundaries - not age, sex or socio-economic background.

It has been very painful for me to see other players ruin their careers through drug abuse. It is equally painful to see our youth - athletes or not - risk their lives with such menaces as crack and other drugs.

As I mentioned, Off Season is designed to help athletes to help society to address social ills and meet public service needs. We recognize that athletes are not immune from society's problems and so we are faced with drug abuse in our own backyard and must work diligently to eradicate it. On the other hand, we recognize that the many professional and amateur athletes who have maintained a drug-free, positive lifestyle can serve as role models influencing youth to avoid drugs or to give them up. We see athletes as playing a vital role, along with coaches, teachers, counselors, community organizations, and government agencies - to educate youth about the dangers of drug abuse and to encourage and guide them to productive living on whatever paths they choose to walk.

1985

Kathleen M. Graham, B.S., Biology, has recently completed the Army's ordinance officer basic course at the Aberdeen Proving Ground in Maryland.

Kenneth K. Haycraft, B.S., Public Administration, is a second lieutenant and has completed the armor officer basic course at the U.S. Army Armor School in Fort Knox, Kentucky.

Joyce Ann Glenn Riggins, M.A., Education, is the assistant principal at Courtland High School in Spotsylvania County, Virginia.

Mary Lynn Takac, B.S., Law Enforcement, is a counselor for the Fairfax County Juvenile Court and Public Schools.

Athlete Pushes Hugs, Not Drugs

William Scheu
Class of '79

William Scheu believes that sports can make a positive difference in the lives of America's youth, and he is using his considerable energies as an athlete and entrepreneur to prove it. This past spring, Scheu introduced his "Hugs Are Better Than Drugs" pilot program to the Palm Beach County School System. Scheu, a 1974 graduate of the Department of Health, Physical Education and Recreation, hopes to eliminate widespread drug abuse among young people by providing them with alternative life choices.

"There don't seem to be many positive role models in life for kids to latch on to," explains Scheu. "I'm trying to fill that gap by showing kids they do have choices—and that they don't have to choose drugs."

As a member of President Reagan's 1984 Athlete All-Star Team and a professional basketball player in his own right, Scheu discovered that sports figures tend to be held in high esteem by young people. With this in mind, he helped form the U.S.A. All-Pro Legends Basketball team, which travels all over the country competing with local sports teams and staging informal rap sessions with the young people who watch the games. Scheu is the player-coach for the team, which includes such basketball greats as Sam Jones (Boston Celtics), Earl Monroe (New York Knicks), and Phil Chenier (Bullets).

Scheu's pilot program is designed to become a part of the school system itself. "After our initial visits to the schools," says Scheu, "we'll leave an evaluator behind to work with school administrators, coaches, and physical education teachers." Scheu says the program is meant to have a more lasting effect than a "one-shot visit by a major sports figure." The team will visit 102 schools in three months; Scheu plans a wrap-up celebrity basketball game, in which all the schools will participate. "We want to make this a cohesive effort," Scheu adds.

Scheu is currently working towards a Ph.D. in sports psychology from the University of Maryland, and already has a master's in psychology. He hopes to bring together his knowledge of sports with his insights into children's behavior, and thereby help them develop a positive self-image.

A tireless volunteer who donates about 30 hours a month to such charities as the Arthritis Foundation, Easter Seals, and the Special Olympics, Scheu is also developing his talents as a sports promoter and has for the past five years organized the Annual Capitol Hill Celebrity Basketball Games, a competition between congressional and senate leaders and NBA All-stars. Proceeds from the games go to designated charities.

Though hard-pressed to pinpoint what motivates him, Scheu is certain of one fact: "It's not what you get out of this world that counts; it's what you put back in to make it better."

-F. Monhon

PREPARED STATEMENT OF

LEE ANN BONNANO

My name is Lee Ann Bonanno, I am 20 years old. I live in the Bronx, New York. I entered Daytop Village in August 1985, because I had finally after 5½ years of getting high and destroying myself and my family, admitted that I had a serious drug problem. I came to the end of my road. After trying to deny the problem for so long. I knew I had to tell someone in order to get the help I needed. I didn't have the strength to do it on my own. On July 10, 1985 I woke up and took a good look at myself in the mirror and saw someone I didn't even know, that really scared me. I ran to my aunt's house and asked for help. From there my parents were called and was all out in the open. My father came over and I though he would scream and yell at me but I was wrong. He came in the door and said "Thank God you finally admitted it, now we can get you the help you need." At this time I was going through withdrawal symptoms. I was a nervous wreck, my eyes looked terrible, I couldn't sleep and the only thing I could keep down in my stomach was water and italian ice. My looks totaly change from getting high. I looked like a pale human skelaton. My parents kept close watch over me that night. They knew I was ready for help and they didn't want me to give up. The next day my parents and I went to see a psychiatrist. The psychiatrist told me I should have not stopped taking the valium cold turkey, because I could have a seizure and die. (Valium was my drug of choice, I was taking 150mg a day or more) The psychiatrist tried to detoxify me at home at the time, by giving me three valium the first day and two per day for a week. That didn't work. The second day of trying this I was taking a shower and got sick to my stomach, I threw up and noticed that I was throwing up blood. I screamed for my mother and she rushed me to a hospital in Westchester County. Whenwe got to the hospital I tried getting out of the car but I couldn't. I was so weak that I couldn't stand up never mind walk. I had to be taken into the hospital by a wheelchair. My mother called up the psychiatrist and she came right over. The hospital couldn't do anything for me because they didn't have a detoxification unit. The psychiatrist caled Westchester County Medical Center. I went there and was examined and admitted to the detoxification ward. I spent 5 days there. Those 5 days there were so awful it was unbelievable. The changes my body was going through were unbarable but I did it. I wanted that poison, those valiums out of my system. When I left detox my psychiatrist thought it best for me to spend some time in a psychiatric hospital to get my thoughts and mind on the right track. I admitted myself in St. Vincents Psychiatric Hospital, where I spent two weeks. When I was there I knew I couldn't go home without some kind of reinforcemnet. I was afaid that I would go back to using drugs. So I spoke to my mother on the phone and explained to her the way I felt. She was one step ahead of me, she already spoke to a counselor at Daytop Village. I asked her to make an appointment for mefor as soon as possible. The appointment was for the day I was released from the hospital. I went to Daytop and had my interview. The counselor to me to give considerable thought about going into residential treatment, which is 24 hours. I didn't want that because I was scared of it, I didn't want to be away from my family.

(3)

I choose to be in treatment in the outreach. Some people said I choose the hard way but I feel I choose the right way for myself. I started treatment August 13, 1985. I started in the daycare program which is Monday to Friday 9-5 and Saturdays 10-3. There are groups everyday and individual counseling, there is also school for residents who want their high school diploma or the GED diploma. I was in Daycare for 9½ months. Then I presented myself for the next phase of the program which is second stage, I felt I was ready to go on with my treatment. The counselors spoke to me and then spoke to my parents. I am now in second stage and working towards my graduation. In second stage I go to groups Monday and Thursday nights 6:30-8:30. Ialso go to school 5 days a week. I go to Robert Fiance School of Hair Design. This always was the career of my choice but I never had the confidence to go for it until now. I should have my cosmetologists license in January and one day I will open my own hair salon.

When I entered treatment I was a liar, thief, manipulator and very immature, all of the classic symptoms of a drug addict. One of the hardest things for me to do was to open up to people when it involved my emotions. I used to stuff everthing down. I was very good at helping everyone else, this made it easy for me not to have anyone confront meor for me to take a look at myself. I was unable to trust anyone with my thoughts or feelings. I resented anyone who tried to have me open up. I ran from them , that included my family. Anytime my mother or fateher got close to the truth of my drug problem I would leave home until the problem would be aside and I would be allowed home and my parents would be so happy to see me the problem would be unresolved. Even in the outreach for the first 2½ months I went through motions and did what was expected of me. Eventually everything caught up with me. As the counselors say they will give you enough rope to hang yourself, and I did because I would take advantage of that they were there to help me and for me to talk to. It took 3 weeks of confrontation from the counselors and the residents to have me open up some. I started allowing myself to hear what was being said, and accept it was true. I finally stopped running and allowed the concept to filter in. In January 1986 the counselors felt it would be very helpful if I was put in a marathon. A marathon is a long extended group which can last from 3-5 days and you let everything out in the open and take a good hard look at yourself. In the marathon there were 11 other residents and 2 counselors. I really didn't trust anyone that I was in the marathon with. During the marathon I knew it was time to start trusting and trust the environment around me. Also to open myself up complетly, which I did. I also made true friends and I never had friends like that before. If I didn't open up in the marathon I'm not sure where I would be now. When I left the marathon it felt like a weight was lifted off of me. It was like a new person was emerging from myself. The change was noticed by everyone. It gave my parentsthe hope and trust that they had lost for me. For the first time in a long time I could be myself and not be afraid of how people would look at me. I didn't run from things I delt with them. That was the point I relly started to change and become Lee Ann, the idividual the winner.

I started with drugs at the age of 12. I smoked a joint with a friend. I really didn't like the way it made me feel so I didn't continue with it. When I was 14 years old I started to hang out with the wrong crowd. They all used one drug or another and they would offer them to me. I didn't want to say no because I wouldn't be cool. It started out with marijuana and drinking alcohol. After awile it progressed to mescaline, ups, downs, all types of pills and cocaine. I 15 years old when I first tried cocaine. I was at a party and eveybody was using it but me, because I was afriad of it. I felt like an outsider because I wass't sniffing it like they were. After a while of everyone saying come on try it I did. After that night I was using cocaine for 4 years. I used to sell cocaine, but I used to sniff more than I sold, so I stopped selling it. When I was 17 years old was when my valium addiction started. The forget me not pills. All my problems seemed to disapeear and nothing bothered me. When I was 18½ years old I tried "Crack". The crack was in a cigarette. The high was a different high than when I sniffed cocaine. I didn't get nosebleeds from smoking crack and I liked that. The high made me feel like I was floating and gave me a haed rush and nothing would bother me when I felt like that. If someone would annoy me when I was high on crack I would start a fight with them or I felt like I wanted to kill them. Crack Made me a very violent person. Something like Dr. Jeckel and Mr. Hyde. I began to rob and steal. I robbed gas stations for money. I would even rip the dealers off to get crack. Alot of problems started to develop at home. The detectives were looking for me because I was involved with an assault. I left home and lived in the woods for 2 weeks because of that. I stole food from the supermarket so I could eat when I was in the woods and stole beer from the deli. When I came home everything was squshed and the person

Before Crack was sold as Crack the people and myself used to cook up our own cocaine so we could smoke it. I have smoked crack in cigarettes, pipes and rolled it up with marijuana. From all the cocaine I sniffed and all the crack I smoked I developed a heart murmur. Its true what they say drugs are a slow suicide. If I would hve continued with drugs I would have been dead or in jail. Thank God I stopped when I did.

I got involved with drugs for many reasons. Peer pressure was one main factor. Not dealing with my problems and not speaking about them. My parents were always there for me, but I refused to see that they were always there to help me, I always thought that they were my enemy. Not dealing with problems, instead I ran from them by getting high. And wanting to belong with what I thought was the in crowd.

Daytop has given me back myself. It is a self help program. Man helping man who helps himself. Daytop has also helped my parents with dealing with having a child with a drug problem. My parents attend parents group once a week. It has helped them a great deal. My brother who is 19 years old went to sibling groups. It let him get out his feelings of having a sister who was a drug abuser. My family and I have the best relationship ever. We are very open with eachother and we talk about what ever is bothering us. We are united again. When you are in treatment and your family gets involved treatment its easier because they understand what you are going through.

Daytop has helped me so much to change and to live and lead a drug free life. I have a whole new outlook on life and myself. I am a winner. I can finally say that Lee Ann Bonanno is an individual a special and important person. I could never thank the counselors and residents enough for being there and giving me the pushes and kicks in the butt when I needed them. I now trust people and truly can care for people. I also now know the true meaning of frienship. If it wasn't for my counselor Vito Tomanelli I would have never been able to share my grief and sucess like this. To let peole know that there is an answer for those who have drug problems.

Drug problems or addictions are not only with the poor or minorities but it is with everyone. Without the proper funding by the government places like Daytop Village Inc. will fade from existence and then there will be not help avalible and that just isn't fair. The drug problem has been to far spread and more and more young ones are easier becoming involved. What is the future America going to be like? Something has to be done. It has to start with the government. Its not fair to tell someone I'm sorry we can't help you because there is no way to get a bed because the facility is to overpopulated. It is not fair to tell them wait three months untill a bed is vacant, God forbid they die in those three months. We need help desperatly! I know I was there myself.

PREPARED STATEMENT OF

JANET BONNANO

(50)

My name is Janet Bonanno, I reside in the Bronx New York.

I am the mother of a recovering drug abuser. I am here to try and make people aware of how wide spread and devastating the misuse of drugs especially CRACK are to the user, the families, and the entire community.

My daughter Lee Ann started using drugs at the age of fourteen. It started off innocantly enough, she thought with MARAJUANA. But once into the drug scene her habits, lifestyle and personality changed drastically. At that time she began seeing a fellow who was seventeen, through him and his friends drugs became a way of life for her. At the time we knew of him from the neighborhood and tried to rationalize his actions were caused by a family that showed no concern for his well-being. There was never any supervision. At the time I felt my daughters attitude and behavior was due to this new lifestyle, never realizing that this was the beginning stages of drug usage. My husband and I opened up our home to my daughter and her boyfriend thinking maybe the stabability of adults whould some how change the situation. When we finally realized that this was an unhealthy relationship, and tried to do something about it. The result was, he came to my house armed with a shotgun. He was under the influence of alcohol and pills at the time, which made his shots go wild and miss my husband who ducked back into the house. This person shot out my front windows and destroyed my front door.

He left after he emptied out the gun and people came out running to see what happened. The 45th Pct. police Dept. were notified, were given his name, address and a description. He lived only eight short blocks fom my house, but the police for some reason were unable to locate him, until my daughter phoned his home to inform his parents, he answered the phone and said he didn't care what happed to him as long as he took us with him, also if the cops came to his home he would "blow them away". The only ones at the time home with him were his younger sisters who were on the extension begging for us to help them, as they didn't know what he was capable of doing at this point. Due to this phone call the police went to his home to apprehend him, and this was only the beginning of a nightmare. His parents arrenged for his bail, and not long after he was back at my home with some of his friends during the early morning, around 1am, and shot up the windows of my husbands van with a pellet gun. He was seen by both myself and my husband. My family and myself lived in constant fear of our lives. I went to court for an Order of Protection which proved to serve absolutly no purpose. During this period my husband and I were pursuing this matter through court when my daughter, who we thought had no contact with him, left home to be with him. At the time she was seventeen years of age, we called the ADA who was handling the court case and he called Family Court to find out what legal right we had with our daughter, and he was told that a child who was 16½ years old had the legal right to leave home and school without parents consent, but they were unable to admit themselves for medical treatment because they were under 18. This was a that made no sense. I felt as if I were knocked flat by the news. After loving and caring for my daughter for 17 years, I had no legal right to see her unless she wanted me to. I tried to keep some communication open with my daughter, which caused personal problems between my huband,son and myself. But I knew my daughters life would depend on somebody being there when she wanted the help, so whatever sacrifice that had to be made I believed was certainly worth it.

When the court case was resolved with him be- sentenced to 18 months in prison, my daughter was no longer wanted or needed by his family, and she returned home. I knew deep inside my daughter still had a drug problem but I still was not able to accept it, and when my daughter wanted to go to school to be a medical assistant, Iwas still hoping maybe this would be the answer. Needless to say it wasn't. It only made it more accessible for her. She was able to get a better knowledge of drugs for the wrong reason. She was unable to hold a job for any considerable length of time.

By this time she had already become involved with another nieborhood drug user, and formed a relationship with him. From that point onward her mental, emotional, and physical well-being deteriorated rapidly. We could no longer deny what we could see happening to our daughter. But still by law we were helpless to anything to save her. Our only recourse was to pray that she would be taken care of until she would want to be helped.

Finally last July after years of worry, and torment my daghter admitted that she was using drugs and went to my sister and her husband and asked for help. Needless to say my husband and I were over joyed that finally we could do something to help her. We felt that at last we were getting our daughter back. My daughter was sent to a detox center which cost $6000 for 5 days, and from there was sent to a psychiatric hospital for 2 weeks which cost $10,000. Luckily my daughter wa still eligable under my husbands health coverage, this paid most of the cost, the rest my husband had to assume. During her hospital stay she applied for medical assistance from the city of New York, we still have never heard the outcome of her application, even though we have complied with all their requirmnets.

While my daughter was still hospitalized, she realized that when she was released that she would need some type of backup reinforcement to stay away from drugs. During a familv conseling sesson I suggested Daytop Village, as a solution to this problem. The psychiatrist was aware of this program and felt it would be most beneficial for my daghter. Lee Ann entered the Daytop Bronx Outreach the day she was discharged from the hospital. She is still with them untill the present time. I knew it was going to be a long, hard road ahead for my daughter. but with her family, Daytop, and her own determination. half the battle was won.

Lee Ann is now woking toward her graduation from Daytop, and is currently attending Robert Fiance School of Hair Design. Upon her graduation from Daytop, Lee Ann would like to work with Daytop sibling groups in her spare time.

I feel the drug problem has been around for many, many years and the only noticeable change that it is more publized, but nothing is being done to crack down on drug dealers and profiteers. Laws were passed regarding them but are never inforced. With all the so called enlightenment about our countries drug problem unless the parents can assume the cost, or the user is entitled medicaid, the help is still very scarce. There are too few free or afordable drug rehibilitation programs. I am quite sure the monies allotted for special forces, who do little more than observe drug transactions and give statistics, could be better used in funding drug rehibilitation centers.

These drug rehibilitation centers such as Daytop have returned to society, productive functioning, responsible human beings.

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Daytop has been in existence for 23 years.

Daytop works with individuals to solve their problems, that made them turn to drugs.

Daytop has drug rehabilitation programs throughout the world (Thailand, Italy, Ireland).

All of Daytop facilities have maximum population. There is a 3½ month waiting list for 24 hour residentail treatment, there is a need for more facilities. Daytop houses, clothes, feeds, gives medical treatment and educates its residents.

Daytop staff consists of Para-Professional (ex addicts who have graduated Daytop's program, and want to give back to Daytop for giving them back their lives). Also on staff are Professional workers such as Phycologist, Sex Therapist etc.

Drugs are not just isolated to people from Getto's, but from professional people to 8th graders in our Catholic schools. I myself went to my daughters high school principal and asked for help and cooperation in trying to help my daughter, and was turned down. I then wrote a letter to the Catholic Archdiocese of New York informing them of this, and was sent a standard form letter telling me there was nothing they could in this matter.

I also have gone on speaking engagements to Catholic High Schools,where my daughter has spoke on drug abuse(the schools requested these speaking engagements)and was later informed that students in these schools who had a drug problem were asked to leave the school. Even if the student was in treatment for his problem. Parents are afraid for the school officials to find out.

In Daytop's Outreaches children as young as 12 years old are on Crack and are coming in for help.

Daytop receives 300 calls a day reguarding Crack alone.

Daytop also works with the parents of drug addicts. There are groups we belong to where we as parents can express our feelings,and help us deal with the problems and work with our children.

Daytop also has a Sibbling Program for brothers,sisters,and children of drug addicts,who have their own feelings and problems,which are caused when there is a addict in the home or family.

The Director of the Bronx Outreach that my daughter is in Kenny Pittius and all of his staff members have been very helpful to me and my family. Any time we needed them they were were right there for all of us. Thank God for them.

My daughter has come a long way since entering Daytop one year ago,so have my husband,son and myself. We have become an open happy family again,only now our family has become larger in members,as Daytop is also our family.

There is an important need for the Government to help fund this drug program,because of the staggering number of drug addicts coming into Daytop for help. If Daytop had more funds avalable to them they could open more doors for the ever increasing amount of addicts looking for help. Without so long a wait for the help and the possobility of losing them forever..When a drug addict comes in looking for help there is no time to put them off and tell them there is no room,come back in 3 months. It may mean their lives.

The youth of america that is begging for HELP is our future. WE MUST HELP!!!

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

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Alcohol, Drug Abuse, and
Mental Health Administration
Rockville MD 20857

FOR RELEASE ONLY UPON DELIVERY

STATEMENT OF

JEROME H. JAFFE, M.D.

DIRECTOR

ADDICTION RESEARCH CENTER

NATIONAL INSTITUTE ON DRUG ABUSE

BEFORE THE

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

AND THE

SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES

U.S. HOUSE OF REPRESENTATIVES

ON

"CRACK COCAINE"

JULY 15, 1986

SUMMARY

JEROME JAFFE, M.D., Director, Addiction Research Center, National Institute on Drug Abuse

Dr. Jaffe begins with a definition of crack. It is cocaine that has been freebased with an alkaline solution so that it can be smoked.

Next, he talks about the extent and consequences of crack use. NIDA's most recent high school drug survey shows that 17% of the class of 1985 tried cocaine, 13% in the last year, and 7% in the last month. This is the highest level ever reported. Data released last week shows that cocaine remains at these high levels among high school students. Also released was a survey conducted among college students, which showed that about 30% of all college students have tried cocaine, and that nearly 40% of all high school grads have tried by age 26-27.

Cocaine use can cause seizures,coma, and death. Cocaine related deaths have increased steadily between 1981 and 1984, as have the number of hospital emergencies related to the use of cocaine. Furthermore, smoking cocaine has increased during the eighties. Finally, treatment admissions for primary cocaine problems have gone up.

Crack is so popular for many reasons, including:
    does not require elaborate paraphernalia
    sells for a lower unit price
    has a rapid effect

NIDA's response to the crack problem includes the following:

Crack has been added to the latest High School Senior Survey.

NIDA's Community Epidemiology Work Group first brought crack to the attention of individuals in the field.

NIDA is doing research on the treatment of cocaine abuse.

NIDA's major effort in the area of public education on cocaine is a multimedia campaign, consisting of radio and television public service announcements and print ads, called: Cocaine. The Big Lie. The announcement tells users to call NIDA's referral hotline, 1-800-662-HELP.

NIDA published an edition of Prevention Networks entitled "Cocaine Use in America."

Mr. Chairmen and Members of the Committees:

I am Dr. Jerome H. Jaffe, Director of the Addiction Research Center of the National Institute on Drug Abuse. Thank you for inviting us to testify today at your joint hearing on the growing problem of "crack" cocaine. I could not help noting that it was almost exactly a year ago that the increasing use of cocaine in this country--and its consequences--was the subject of another hearing by the Select Committee on Narcotics Abuse and Control. At that hearing last July, our Department testified that in the past 15 years cocaine abuse had grown from a relatively minor problem to a major public health threat, and we reported that cocaine users were shifting from snorting or inhalation to newer more dangerous routes of administration, such as freebase smoking. That trend toward the use of these routes of administration has now intensified, and the problems associated with it have become a matter of grave national concern. The manufacturing of "crack" cocaine emerged in 1985, and this new form of the drug is appealing to many users because it is conveniently packaged, easily ingested by smoking, and initially affordable.

Definition of "Crack"

Since "crack" cocaine is a new form of freebase cocaine, not a new drug, it might be helpful to provide a definition of the term.

If cocaine is to be smoked, it must be converted to a freebase form. Previously, an alkali such as ammonia or bicarbonate of soda was added to cocaine hydrochloride to form the cocaine base and then extracted using a solvent such as ether. However, individuals preparing freebase discovered that the extraction step could be eliminated and that cocaine freebase could be precipitated directly from the alkaline solution, by evaporating or pouring off the water. This results in a waxy, soap-like material, which is called "crack." This process made it simpler for dealers to mass-produce individual cocaine doses and eliminated the need for individual users to prepare their own material using dangerous organic solvents.

In other words, "crack" is a street name for cocaine freebase prepared by a method which does not use solvents. Besides "crack" and "freebase," smokable cocaine is also known as "Roxanne," "rock," "gravel," "base," "baseball," "white tornado," and "snow toke." Even though the variety of names for smokable cocaine can be confusing, the reality is that they all are cocaine. Nevertheless, inexperienced users may not realize that when they are buying "rock" or "crack," they are buying cocaine.

Extent and Consequences of "Crack" Use

In May 1985, NIDA conducted a field investigation in New York City and initially brought "crack" to the attention of Federal and State authorities. In October 1985, the New York Drug Enforcement Task Force made the first significant seizure of "crack." While enough time has not elapsed at this point to provide data specifically on "crack," NIDA's data from the National High School Survey did show that the Class of 1985 were using cocaine at an unprecedented level. Seventeen percent had tried cocaine, 13 percent had used the drug in the last year, and 7 percent in the past month. Most cocaine users do not start using the drug until after high school, but increased numbers of young people are now beginning to use cocaine during these vulnerable years.

Data released just last week from a national survey of drug use among college students, funded by NIDA, revealed that cocaine use remains at peak levels among high school students and young adults generally. Researchers at the University of Michigan's Institute for Social Research, which also conducts NIDA's High School Senior Survey, found that by the end of their fourth year of college, roughly 30 percent of all college students will have tried cocaine and that nearly 40 percent of all high school graduates have tried it by age 26 or 27.

Data from the Drug Abuse Warning Network (DAWN) provide an indication of the health consequences associated with the use of cocaine. DAWN, a NIDA sponsored survey of selected hospital emergency rooms and medical examiner offices located primarily in 27 metropolitan areas in the United States, provides information on morbidity and mortality associated with illicit drug use.

The severity of the potential health consequences associated with the use of cocaine was underscored by the recent deaths of two well-known athletes. Although these deaths shocked and saddened the Nation, they did not surprise those of us in the drug abuse field who have long been on record in reporting that cocaine overdose can result in seizures, coma, and death from respiratory or cardiac arrest.

The number of cocaine-related deaths reported to DAWN by medical examiners located in 25 metropolitan areas throughout the country increased from 195 in 1981 to 580 in 1984. Provisional data for 1985 indicate that cocaine-related deaths are continuing at unprecedented high levels, with 563 deaths reported to date. It should be noted that mortality data from the Nation's largest city, New York, are not included in these statistics.

Over the past 5 years the number of hospital emergencies related to the use of cocaine tripled from over 3,000 in 1981 to almost 10,000 in 1985. Five metropolitan areas made up more than 50 percent of all cocaine mentions in 1985--New York, Miami, Los Angeles, Washington, D.C., and Detroit. Increases were observed in each of these areas. In New York, for example, cocaine emergency room mentions increased from 1,122 in 1981 to 2,390 in 1985. In Miami, the number of cocaine emergency room mentions increased from 249 to 953 over the 5 year period. It should be noted that while at least 70 percent of emergency room mentions related to cocaine are still among patients 20 to 34 years of age, the increasing use of "crack" could well change this pattern.

DAWN data also suggest that smoking cocaine, or freebasing, has been increasing during the eighties. In the first quarter of 1984, 86 of the cocaine emergency room patients, or 4 percent, reported smoking as their route of administration. By the fourth quarter of 1985, 382 cocaine patients or 13 percent reported smoking. In the total DAWN system for the entire year of 1985, 11 percent reported smoking. Of these, 1,242 patients, or 78 percent, were reported by the metropolitan areas of Miami, Los Angeles, Detroit, and New York. In each of the metropolitan areas of Miami and Detroit, for example, approximately 16 percent of the total cocaine emergency room visits reported smoking cocaine in 1985. In Los Angeles, 565, or 35 percent, reported such use of cocaine during this period.

Data on treatment admissions provide another indication of the seriousness of a particular drug abuse problem. Treatment data from 19 States and the District of Columbia indicate an increase in the percent of clients admitted to treatment for a primary cocaine problem from 3.8 percent in 1979 to 9.7 percent in 1983. Although the treatment data for 1983 and 1984 are no longer comparable to previous data because they reflect less than half the States, the data are still useful in looking at distributions by route of administration. Among primary cocaine clients admitted to treatment in 1984, 18 percent reported smoking cocaine as their usual route of administration. This compares to 5 percent reported in 1981.

The Popularity of "Crack"

There are a number of reasons why "crack" has become so popular. It appears that the role of smoking as the drug's route of administration is more important than its purity. "Crack" does not require the use of elaborate paraphernalia; it is usually smoked in a glass pipe. This appeals to the many buyers of "crack" who are first-time users of cocaine. It sells for a lower unit price, which attracts younger and less affluent street customers. To the experienced user, an attractive aspect of "crack" is its rapid effect; these users know that when it is smoked, cocaine's onset of action is much more rapid than when it is snorted.

Previously, cocaine was generally purchased in lots of at least a gram for a price averaging $100 per gram. "Crack," on the other hand, is packaged and marketed in small vials that were designed to hold eyeglass or watch parts. Each small vial holds one dose--approximately 50 to 100 mg. of cocaine. Introducing the unit dose concept to the marketing of cocaine effectively removed the price barrier which previously existed for experimentation with this drug. However, since cocaine is highly addictive in this form, the "crack" user may have to buy so much "crack" to satisfy his or her craving, that it becomes even more expensive than snorting cocaine or using it intravenously.

Some young people may not be aware that "crack" is cocaine and may be under the misconception that they are smoking some type of "new" drug. Peer pressure is intense during childhood and adolescence and cannot be underestimated as a factor in the use of any drug, especially when young people are not aware of the extreme risks associated with a particular substance.

The Federal Response to the Problem

Because so many people are clearly experiencing major problems from the use of cocaine, in whatever form, research into the drug has been and remains an extremely high priority for the National Institute on Drug Abuse. Clearly, the route of administration a cocaine user chooses is extremely significant in determining the effect the drug may have on him or her. NIDA-funded researchers have now been able to quantitatively compare the disposition and pharmacological effects of cocaine--including both the psychological "high" and the cardiovascular effects--following freebase smoking, intravenous injection, and intranasal administration. Researchers have found that the maximum effects for heart rate acceleration, blood pressure elevation, and self-reported "high" occurred at about the same time for the intravenous and smoking routes of administration, while the maximum effects were delayed somewhat for the intranasal route. For example, the average time to peak heart rate acceleration was 10, 12, and 19 minutes respectively for the intravenous, smoked, and intranasal--or snorting--routes. Similarly, the self-reported "high" effect reached a maximum about 20 minutes after intranasal administration, as opposed to 5 minutes after IV use and 7 minutes after beginning smoking.

Researchers have also found that plasma concentrations of cocaine following smoking of 50 mg cocaine freebase were almost equivalent to those following an intravenous dose of 20 mg. The maximum plasma concentration was reached at 5 minutes after smoking, while the maximum concentration was not reached until 30 to 40 minutes after intranasal inhalation.

In order to get a better picture of the epidemiology of various forms of cocaine use, we are undertaking efforts in a number of different areas. Data from our latest annual High School Senior Survey, which we plan to release in late 1986, includes specific questions on the use of "crack" by seniors in the class of 1986. The 1985 National Household Survey, which will be released later this summer, did not include questions on "crack" *per se*, since it was in the field before "crack" emerged as a problem, but it did ask about routes of administration for cocaine. This would effectively pick up any users of "crack" since it is always smoked.

Mechanisms other than surveys are used to assess the extent of the problem. For example, NIDA has a Community Epidemiology Work Group, which twice a year brings together local experts from major metropolitan areas to identify and assess local drug abuse trends and to share this information. At the most recent meeting of this group, held last month in New York City, participants discussed ethnographic approaches for identifying "crack." NIDA epidemiologists also conduct field investigations, such as the one which I mentioned earlier which first brought crack to the attention of individuals in the field.

In an experiment to ascertain the extent to which data from opinion polls can be used to supplement data from our major drug surveys, questions on the prevalence of alcohol, marijuana, and cocaine use have been added to recent Gallup Polls. Because differences in methods are still being assessed, we do not know how comparable these data are to the National Household Survey, but we will know within the next few months whether we should further pursue this means of getting more current information on drug trends.

Research into the treatment of cocaine abuse is a major area of emphasis for NIDA. Treatment can be both protracted and costly, but we are continuing to investigate several promising approaches. Researchers are investigating such topics as: the use of antidepressant and other medications in the treatment of cocaine withdrawal symptoms; the efficacy of outpatient programs that combine individual, group, and family therapy; and the use of self-help groups as part of aftercare programming for persons treated for cocaine dependence. Last year, NIDA published two monographs which summarized recent findings in these areas: Cocaine: Pharmacology, Effects, and Treatment of Abuse and Cocaine in America: Epidemiologic and Clinical Perspectives.

Because cocaine addiction is so difficult to treat and relapses are common, our first line of defense is to prevent individuals from beginning to use the drug. Failing that, it is important to try to dissuade occasional users from continuing to use the drug. Nevertheless, we must recognize that cocaine is an extremely addictive drug and that many individuals using it cannot discontinue use without help. Our public education efforts in the area of cocaine are aimed at dependent and occasional users, as well as the uninitiated.

Our major effort in the area of public education on cocaine is a multimedia campaign, consisting of radio and television public service announcements and print ads, called: COCAINE. THE BIG LIE. It was launched in March and began airing in mid-April. The campaign is designed to reach users, potential users, and those close to users--wives, parents, and job supervisors. In originally planning the campaign, we took into account current epidemiologic findings and specifically targeted it to young working adults, men and women, age 18 to 35, both blue-collar and white-collar, of all income levels. It features people from all walks of life who have been addicted to cocaine. They describe the seductive and addictive qualities of the drug and the devastating effect cocaine has had on their own health, careers, and relationships. At the conclusion of my testimony, I would like to show you the first wave of television spots, which we think eloquently portray the terrible dangers of the drug.

The next phase of the campaign will be targeted to high school and college students. The campaign is designed in specific phases so that we can adapt it as new information emerges, and we are currently looking into ways of using future campaign materials to educate the public about "crack" and the dangers associated with it.

In conjunction with the campaign, NIDA has made available a new publication, COCAINE ADDICTION: IT COSTS TOO MUCH, in English and Spanish It provides a brief, clear cut message about the dangers of cocaine abuse. Numerous individuals and organizations across the country have already requested this booklet.

In addition, NIDA has published a special edition of Prevention Networks, entitled "Cocaine Use in America." This issue focuses on the cocaine phenomenon, explores the drug in its many forms, and details its effect on the body, mind, and on American society. The two most recent issues of NIDA Notes (which is distributed to more than 10,000 organizations and treatment programs) both contained articles specifically on cocaine, "crack," and current treatment initiatives.

NIDA has also set up a toll-free treatment referral hotline number which is cited on all the media campaign ads. The number, 1-800-662-HELP, has serviced approximately 6,000 callers since it began operating on April 15. Calls have come in from every State and from people in all walks of life, indicating that the ads are being widely aired and are reaching substantial numbers of people. The largest number of callers are from three States: Florida, California, and New York. Because of the tremendous response to the program, we will be expanding the hotline with additional lines and staff.

Since the campaign is geared to the largest group of cocaine users, working people aged 18 to 35, certain activities have been initiated to reach these individuals in the workplace, such as having the print ads run in employee newsletters and other communications channels. We also have been working with representatives of the business community to urge their participation in employee education about cocaine. A special ad aimed at executives and supervisors is being prepared for the Business Community Press, a group of publications aimed at leadership in the business community.

Baseball Commissioner Peter Ueberroth will be using NIDA's cocaine prevention campaign materials to promote a strong cocaine prevention message to baseball fans. He will be displaying posters, broadcasting the public service announcements at games, and placing print advertisements in weekly baseball programs. In addition, just last week, Mr. Ueberroth and NIDA collaborated in the production of additional public service announcements on cocaine, which feature famous baseball celebrities who have not used drugs to provide young people with positive role models.

In addition to this national media campaign and the activities associated with it, NIDA is involved in a number of other major prevention initiatives which we hope will have an impact upon cocaine use, especially by young people. For example, the Institute has identified Oakland Parents in Action, a comprehensive community project, as a model for reaching minority communities with citizen-involved drug abuse prevention programming, and is helping to replicate this effort in other ethnic minority communities in Atlanta, Georgia, Corpus Christi, Texas, and the Hopi Indian Reservation in Arizona. NIDA is also working with The Links, a national Black women's civic organization and with two black college sororities, the Delta Sigma Theta Sorority and the Zeta Phi Beta Sorority, to promote local citizens' involvement in drug and alcohol abuse prevention.

NIDA is promoting the implementation of prevention strategies that have been found to work in the school setting and the formulation of school policy relating to the drug issue. While we continue to identify, describe, and assist in disseminating school curricula designed to prevent drug and alcohol abuse, we are convinced that these curricula themselves are not effective without a support network--of parents, teachers, coaches, and other role models--in place to back them up. Helping communities to develop these support networks is a major focus of our prevention efforts. College age students are a new focus of those efforts.

NIDA is also involved in a special initiative designed to reach out to youth groups who appear to have been overlooked in prior prevention efforts. These target groups include runaway youth, children of substance abusers, juvenile delinquents, and foster care children. In addition, NIDA has a cooperative program with the Office of Juvenile Justice and Delinquency Prevention to conduct conferences and provide substance abuse technical assistance and training to Juvenile Probation Departments.

NIDA has targeted health professionals to learn how they can be active in drug prevention and intervention on behalf of their patients and their community. New training materials have been developed on substance abuse for pediatricians and family doctors to clarify their potential role in prevention, intervention, counseling, and/or referral; similar materials are being developed for nursing staff. Various collaborative efforts are underway with such groups as the American College of Obstetricians and Gynecologists and to the American Nursing Association for the development and dissemination of materials on drug abuse. In 1985, contracts were awarded to the American Psychiatric Association, the Ambulatory Pediatric Association, the Society for Teachers in Family Medicine, and the Society for Research and Education in Internal Medicine to enhance medical education in substance abuse.

In August, NIDA will hold an important national prevention conference, "Sharing Knowledge for Action," which will bring together prevention staff from all over the country. The conference will emphasize research, policy, program applications, and networking in four theme areas: 1) prevention and schools; 2) family; 3) community; and 4) policy. "Crack" will be a topic of significant interest at this meeting.

We are frustrated, as we know you are, by the fact that drug abuse and the problems associated with it continue not only to exist, but to show up in new and frightening forms, such as "crack" use. Nevertheless, we do believe it is imperative that we continue to seek knowledge about and ultimately answers to the problem--whether they be in research, prevention, or treatment--and to communicate that knowledge as broadly as possible. We look forward to working with you in these endeavors and thank you for focusing national attention on a problem that concerns us all.

U.S. Department of Justice (87)

Drug Enforcement Administration

Statement

of

DAVID L. WESTRATE
Assistant Administrator for Operations

Drug Enforcement Administration
U.S. Department of Justice

on

The Crack Problem

before the

Select Committee on Narcotics Abuse and Control
U.S. House of Representatives
Charles B. Rangel, Chairman

and the

Select Committee on Children, Youth and Families
U.S. House of Representatives
George Miller, Chairman

July 15, 1986

Chairman Rangel, Members of the House Select Committee on Narcotics Abuse and Control, and Chairman Miller, and Members of the House Select Committee on Children, Youth and Families: I am pleased to appear before you this morning to discuss "crack," a smokable, free-base form of cocaine.

There has been much publicity recently about what has been called an epidemic of crack, and, on behalf of the Drug Enforcement Administration, I am pleased that your committees are addressing this serious issue.

I would first like to give you some background on crack before I discuss DEA's role regarding halting this newest drug abuse problem.

The first product to be made from the leaves of the coca plant is coca paste, which is used to produce cocaine base. Dried cocaine base is usually dissolved in ethyl ether, acetone, or a mixture of both and filtered to remove solid impurities. A mixture of acetone and concentrated hydrochloric acid, or ethanol and concentrated hydrochloric acid is added to precipitate cocaine hydrochloride. The precipitate is filtered and dried carefully, using bright light, to produce a white, crystalline powder, cocaine hydrochloride, otherwise known simply as cocaine.

Cocaine hydrochloride, available on the street at 30 to 40 percent purity, remains the most common coca product in the United States. The predominant methods of cocaine abuse continue to be primarily through inhaling and, to some extent, injecting cocaine hydrochloride. In the past year or so, however, the use of "crack" has become increasingly prevalent in certain areas.

Because cocaine hydrochloride will largely decompose if smoked directly, the hydrochloride must be converted back to a relatively pure base state, or free-base, before it is suitable for smoking. Free-base is either made the traditional way by using volatile chemicals, most notably the highly explosive ether, or by a heating and cooling method that produces crack.

In traditional free-basing, cocaine hydrochloride is mixed with baking soda or ammonia, and then with water, and ether. The ether then evaporates to produce a powdery cocaine base, which is smoked in a water pipe or sprinkled on a tobacco or marijuana cigarette and smoked.

Heating free-base that is not completely dry and therefore contains ether can result in an explosion. Ether is not used to make crack. Rather, crack is made from either baking soda or ammonia. Crack is safe from explosion since no ether is used.

Crack is an off-white color resembling coagulated soap powder or pieces of soap. Crack made either with baking soda or ammonia is smoked in a water pipe or sprinkled over a tobacco or marijuana cigarette and smoked. The word "crack" either comes from the crackling sound made when it is smoked before it dries, or from its occasional resemblance to cracked paint chips or plaster.

It is sold on the streets, usually in small vials, glassine envelopes, or sealed plastic bags, at purity levels between 60 and 90 percent. Although amounts vary, small vials contain an average of 100 milligrams of crack, which cost approximately $10. Preliminary information indicates that, nationwide, 250 milligrams cost $25, and 500 milligrams cost $40-$50. A ten-dollar vial of 100 milligrams can provide one, two or three inhalations when smoked in a pipe, depending on how deeply the user breathes.

The low price per dose may attract crack buyers, while giving the dealer a substantial profit. Since crack users often crave more immediately after smoking, they purchase more cocaine in the crack form than they may have if they had used cocaine hydrochloride regularly.

Crack is sold on the street or in crack houses, also known as rock, base, free-base, or smoke houses. Crack houses generally are apartments or houses. The definition of what constitutes a crack house varies from city to city. In some cities, a user can both purchase and smoke the drug on the premises. In others, a user can only purchase the drug and is not allowed entry. Still in others, a user must bring his own crack, because the drug is not sold on the premises; the house simply provides a room and a pipe for smoking crack.

It is generally believed that the desire for a more intense "high" without the complications and dangers involved in free-basing with ether or injecting cocaine with hypodermic needles that could spread AIDS has been the impetus for the smoking of crack as an alternative form of use.

The euphoric effect produced by smoking crack is far more intense than if the cocaine is ingested through inhaling and at least equal to, if not surpassing, that obtained through injection. Crack's effects occur rapidly, generally in a few seconds, and usually last from five to ten minutes. Following this, the user may experience a restless irritability accompanied by a severe depression and an almost insatiable craving for more of the drug.

Crack affects the body in several ways: Stimulation of the central nervous system produces euphoria, hallucinations, irritability, and paranoia. Blood pressure increases and may cause, in some cases, brain hemorrhage or convulsions. The heart beats more rapidly and may become irregular, causing a heart attack. Chronic crack smoking may lead to hoarseness or bronchitis.

Crack has emerged as a major drug problem in less than a year. As a result, data on usage, emergency room mentions, and arrests have not focused on crack as an individual category of drug abuse apart from cocaine.

For instance, the Drug Enforcement Administration relies primarily on DAWN, the Drug Abuse Warning Network, for information on drug-related injuries and deaths. DAWN is a Federally-funded, large-scale data collection system which has approximately 750 emergency rooms reporting nationwide. For the reporting purposes of DAWN, drug abuse is defined as the non-medical use of a substance for psychic effect, dependence, or suicide attempt. There are statistical reasons for believing that trends and patterns gleaned from emergency room statistics are parallel to those in the abusing population at large.

Since only 750 emergency rooms report, DEA has developed a model that uses mathematical techniques for estimating the number of drug abuse episodes which could be expected if DAWN included all emergency rooms across the country. As extrapolated from DAWN, nationwide estimates of emergency room episodes for cocaine in the first two quarters of FY 1986 increased by approximately 3,000 episodes, or 23 percent, over the same period in FY 1985. Cocaine mentions showed the only appreciable increase of major drug categories. I believe that this recent increase in DAWN cocaine mentions can be directly attributed to crack abuse.

Another way of looking at DAWN statistics is through identifying how the drug entered the patient's body. It should be noted that it is not always possible for DAWN hospital personnel to determine how the drug was taken; therefore, these statistics may not be as complete. Although the number of cocaine-related hospital emergencies, or injuries, involving cocaine smoking as the primary route of administration is relatively small compared to those involving injection or nasal inhalation, they are increasing at a much higher rate. From 1984 to 1985, the number of DAWN injuries recorded due to cocaine smoking rose from more than 600 to more than 1,100, an increase of 83 percent. Much of this increase is believed to be due to the smoking of crack, as opposed to smoking of more traditional free-based cocaine.

The 800-COCAINE Hotline has gathered some statistics on crack abuse that show preliminary trends among users. They conducted a random sample of 458 primary cocaine users who called the hotline during May 1986. Of these 458 persons, 144, or 33 percent, were using crack. The majority of crack users, 72 percent, were males, 94 percent were 20-39 years old, and 57 percent earned more than $16,000 a year. They spent over $100 per week on the drug. The vast majority, 81 percent, said they had switched from "snorting occasionally" to smoking crack.

These hotline statistics from May 1986 also indicate that 82 percent of the callers using crack reported a compulsion to use the drug again as soon as the brief high wore off; 78 percent reported the onset of compulsive use and significant drug-related problems within two months of first use. As to side effects, callers experienced the following:

- The majority experienced severe and life-threatening psychiatric and physiologic side effects
- 64 percent had chest congestion
- 40 percent had a chronic cough
- 85 percent experienced severe depression
- 78 percent reported irritability
- 65 percent felt paranoia
- 40 percent had memory lapses
- 31 percent showed violent behavior

- 18 percent attempted suicide
- 7 percent had brain seizures with a loss of consciousness.

To our knowledge, at this time there is no comprehensive analysis of the crack problem, either from a health or enforcement viewpoint. We have collected data voluntarily gathered by various health or police professionals. For instance, New York City detectives have reported, through "empirical evidence," that crack has attributed to increases in homicides, and that crack accounts for approximately 50 percent of all cocaine arrests in New York today.

DEA's own enforcement information on crack is also incomplete. As in the case of DAWN statistics, DEA's data collection system for drug arrests do not differentiate between cocaine hydrochloride and crack. DEA total arrests for all drug categories for the first half of FY 1986 as compared to the same period in FY 1985 increased by more than 2,000 persons, from approximately 6,000 arrests to more than 8,000, almost a 35 percent increase. Arrests in cocaine cases increased by more than 1,500 during the same time period, from more than 2,500 to more than 4,000 persons, almost a 60 percent increase. Cocaine arrests, in fact, accounted for nearly 80 percent of the total increase in arrests.

Since this enforcement data is incomplete, DEA last week began an extensive, in-depth intelligence survey through all of its domestic field offices to try to discern the use and availability of crack, its purity, and price. We are also looking for the general locations, city or suburb, street or crack house, where it is being sold; how it is packaged; how much is usually seized from a dealer or a user; have arrests for possession or sale of crack increased; have the local police departments mounted special enforcement campaigns to curtail the sale and distribution of crack; are local medical and drug treatment facilities experiencing an increase in the number of admissions for crack usage; what demographic information on the user is available; and what is the extent of the media attention or the public awareness in each area.

Local drug treatment professionals and police departments nationwide are being contacted for this study. We anticipate it will be completed in two months, at which time DEA will use the results to help define our strategy for dealing with the crack problem.

To begin our formal inquiry into the extent of the crack situation, DEA held a day-long conference on crack in June in New York City. Participants included DEA officials, law enforcement officers, health and medical experts, and officials of the U.S. Justice Department, and the National Institute of Drug Abuse.

I believe that it is important, at this point, to reemphasize DEA's role in drug law enforcement. As with any drug trafficking situation, DEA targets the uppermost echelon of the traffic, focusing on those involved at the source and those responsible for wholesale distribution of illicit controlled substances. DEA then works with state and local enforcement agencies through a variety of programs to address drug trafficking activities that are not of international or interstate dimensions, but rather are occurring at the mid-level or retail level of drug distribution. Progress against the crack problem is tied directly to our ability to impact on the original cocaine source and major trafficking smuggling and distribution organizations. This is the area where we will continue to place the majority of our efforts. Efforts in local areas will be taken in cooperation with local police or established task force programs.

DEA supports 34 State and Local Task Forces and 13 shared funding task forces in which DEA Special Agents and officers from state and local law enforcement agencies cooperate on narcotics investigations in order to disrupt the illicit drug traffic in certain geographic areas. Based on our limited reporting thus far, the major cities which are experiencing crack problems all have these task forces.

Additionally, DEA will use all of its intelligence resources, foreign and domestic, strategic and operational, to keep state and local police officials abreast of any new information which DEA develops regarding crack distribution.

In the international arena, DEA coordinates or participates in a range of enforcement and cooperative efforts to control cocaine production and distribution in South America. Along with other Federal agencies, DEA encourages South American source countries to eradicate coca plants and seize and destroy cocaine base and hydrochloride laboratories.

The control of essential chemicals to manufacture drugs like cocaine requires the cooperation of many nations. For several years, DEA has spearheaded Operation Chem Con to reduce the availability of essential chemicals used in the illicit manufacture of cocaine hydrochloride and other drugs. In 1985, approximately 2,600 55-gallon drums of ether were seized in the United States and abroad. This amount of ether would have produced more than 30,000 kilos of cocaine hydrochloride, worth nearly one billion dollars. Chem Con acetone seizures totalled more than 4,500 55-gallon drums, which would have processed about 54,000 kilos of cocaine. In 1985, these successes were achieved through cooperation of law enforcement agencies and private firms predominantly in the countries of Germany, Brazil, France, Colombia, Ecuador, Venezuela, Panama, and the Netherlands.

Operation Stop Prop is another joint operation that started and mainly operates in Latin America, but which is expanding into the Caribbean. Its goal is to minimize general aviation smuggling of cocaine using a sophisticated intelligence program to find clandestine labs and airstrips, and the aircraft used by traffickers.

Operation Pipeline is a domestic operation begun by the New Mexico State Police in 1983 to identify, intercept, arrest, and prosecute cocaine couriers using major highways in the United States. DEA resources are being used to train state and local police for this operation in over 30 states from Florida to the West Coast. Over 70 cocaine and money seizures have been made by the New Mexico State Police.

One of the most exciting developments is the success of IDEC. The International Drug Enforcement Conference, called IDEC, was initiated by DEA in 1983 to foster cooperation with South America and Central America by creating a network of law enforcement executives with the unified goal of eradicating drug trafficking. IDEC most recently held its fourth annual meeting in April in Argentina. Resolutions were passed to work on multilateral extradition treaties; the enactment of more uniform penalties for narcotic crimes; adopt the goal of Operation Stop Prop; and the furtherance of regional narcotic enforcement programs.

In combination with enforcement strategies to deal with crack, DEA is also approaching the problem through its demand reduction emphasis on prevention and education. DEA now includes a presentation on crack by a DEA Special Agent in each of the DEA-sponsored Sports Drug Awareness Program seminars for high school coaches. These coaches, in turn, can help reach 5.5 million student athletes, who may act as role models, using positive peer pressure to keep other students from using drugs.

DEA is also editing a videotape of the recent New York City conference on crack that covers the extent of the crack problem, its method of manufacture and distribution. DEA field offices will be able to use this videotape in public education programs and law enforcement training across the country.

CONCLUSION

DEA's continuing area of primacy is to reduce the flow of all cocaine into the United States. The different aspects of the national strategy to address the cocaine problem, which also encompass crop eradication and other cooperative efforts in the international sphere, investigations and prosecutions of the upper levels of cocaine trafficking, and drug demand reduction, will ultimately have the desired effect on the crack problem as well.

Mister Chairmen, I appreciate the interest your Select Committees have shown with regard to the fast-growing problem of crack, and its effect on our nation's continuing drug abuse situation. I will be pleased to answer any questions you may have.

The Drug Enforcement Administration

DEA sees "crack" as a major drug problem which has emerged in less than a year. Data on usage, emergency room mentions, and arrests have not focused on "crack" as an individual category of drug abuse apart from cocaine.

To DEA's knowledge there is no comprehensive analysis of the crack problem either from a health or enforcement viewpoint. The New York City Police Department's Detective Division has reported, through "empirical evidence" that "crack" is attributed to increases in homocides, and accounts for approximately 50% of all cocaine arrests in New York City. Other such information currently available to DEA has largely been gathered by various health and law enforcement professionals.

DEA concedes that its own enforcement information on "crack" is also incomplete. Their data collection system for drug arrests do not differentiate between cocaine hydrochloride and "crack". They do, however, offer the following statistics:

1. Total arrests for all drug categories for the first half of FY 1986, as compared to the same pedriod in FY 1985, increased by more than 2,000 from 6,000 arrests to more than 8,000, almost a 35% increase
2. Arrests in cocaine cases increased by more than 1,500 during the same time period, from more than 2,500 to more than 4,000 persons, almost a 60% increase.
3. Cocaine arrests accounted for nearly 80% of the total increase in arrests.

Last week the Drug Enforcement Administration commenced an extensive intelligence survey through all of its domestic field offices to try to discern the use and availability of "crack", its purity and price. Local drug treatment professionals and police departments nationwide are being contacted for this study. DEA estimates that the study will take approximately two months to complete.

TESTIMONY OF WILHELMINA E. HOLLIDAY, DEPUTY COMMISSIONER,
COMMUNITY AFFAIRS, NEW YORK CITY POLICE DEPARTMENT

BEFORE THE

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL AND THE
SELECT COMMITTEE ON CHILDREN, YOUTH AND FAMILIES

DATE - JULY 15, 1986

Distinguished Members of Congress, first I would like to thank the House for this opportunity to present some pertinent information about cocaine hydrochloride in its freebase form and its ramifications in the City of New York from the Police Departments's perspective.

Commonly called "crack", this drug and its abuse has reached truly epidemic proportions in my city. The pharmacology and medical aspects of this drug and its abuse are topics about which my department is not technically competent to expound on in detail, but the social and behaviorial aspects are areas in which we are, sad to say, becoming quite expert.

Nevertheless, it might be useful for all of us to review some basics about "crack".

Pharmacologically, "crack" is freebase cocaine sold in the form of small, ready-to-smoke crystals, or "rocks". It is basic cocaine alkaloid which has been chemically "freed" from its parent compound, cocaine hydrochloride, a salt. The "crack" sold in New York City is usually manufactured by one of two methods:

> In method #1, ordinary street cocaine or high-quality cocaine (cocaine hydrochloride) can be combined in a 2:1 ratio with ordinary baking soda---sodium bicarbonate---and dissolved in water to make a paste. The paste is then heated while being stirred until all water is evaporated out of the paste. The solid residue remaining is then broken into small pieces known as "rocks" and sold in that form. The "rocks" may range in color from white to a light tan.
>
> In method #2, less common, ordinary street cocaine is mixed with ammonia and/or powder-form amphetamine and cooked, and the mixture resulting is then dissolved in water, filtered and allowed to dry. The crystaline residue is then broken into "rocks" and sold in that form.

Once prepared in "rock" form, "crack" is usually packaged in tiny see-through plastic or glass vials containing larger quantities have also been seized which sell for higher prices.

Medically, "crack" can and does precipitate a rapid and deep addiction in the user, and that addiction seems to control the user's life and behavior. (Many "crack" users are also addicted to alcohol, tranquilizers and other illicit drugs --- often taken to relieve the more unpleasant side-effects of "crack".

Psychologically, at the early stages of "crack" use, the drug seems to induce a wide range of pleasurable feelings---energy, euphoria, self-confidence, talkativeness, sexual stimulation, and a feeling of happiness and relief from stress. Continuing use, however, shows a development of tolerance and ultimately, once the addiction takes hold of the user, "crack" produces unpleasant feelings, such as depression, paranoia, irritability and sexual impotence. Some users become suicidal and extremely violent and act out their feelings.

It is precisely with these ramifications that the use of this dangerous, addictive drug becomes a matter of concern for law enforcement and the whole criminal justice matrix. The social consequences of "crack" use and addiction often leads to personal, social, legal, financial and other problems for the addicts. The drug becomes the most important thing in the user's life, overcoming such other common values as personal health, eating, sex, family life, and career. Because of the highly addictive nature of the drug, "crack" often requires its users to spend enormous amounts of scarce money on the drug, and the consequence---especially for the economically disadvantaged---is very often a major contributor to drug-related crimes, including dealing in the drug, theft and robbery, burglary, violence and automobile accidents (often resulting from the combined use of "crack" and alcohol). Clearly, "crack" is a menace to the community in which it is found. That has been our experience.

Theories as to why people use drugs, in general, abound; they are probably all---to one degree or another---at least partially correct. The apparent meteoric rise in popularity of "crack" as a drug of choice seems to depend upon the speed and the rapidity of the euphoria it produces in the user, presently estimated at from eight to ten seconds. (This contrasts with the two or three minutes it takes for ordinary cocaine to take effect, for example.) "Crack" is also popular because of the way it is ingested---smoked, rather than snorted. The relatively cheap price of a "hit" also contributes to its popularity---about $10 a vial---as compared to ordinary cocaine and even marijuana, especially among the young. Police Department information also suggests that many intravenous drug users---those who inject drugs---have moved to "crack" precisely because of the AIDS epidemic and fear of contracting that disease through using shared needles. Statistics indicate that about one third of the AIDS victims in New York City are intravenous drug users who are believed to have contracted the disease through sharing needles. Some prefer smoking "crack" to swallowing pills.

"Crack" is most commonly used by pulverizing the "rocks" and sprinkling the result on a regular cigarette or a marijuana "joint", or by vaporizing the "rocks" at the top of a specially-designed glass pipe by applying a butane flame to the pipe's glass bowl and inhaling the vapor through the pipe's stem. Thus the vaporized "crack" is drawn from the heated bowl down through a cool water reservoir at the bottom of the pipe to cool the vapor and then sucked into the user's mouth, into the lungs and thus into the bloodstream and to the brain. The whole process may take from four to ten seconds, once the "crack" is vaporized.

Compared to common street coke, cocaine hydrochloride, "crack"---from a user's point of view---looks good.

The street price for "crack" is about $10 a hit, while cocaine can range from $5 and up, depending upon the market, the relative purity and other factors. The length of the $10 hit of "crack" is from 5 to 7 minutes, while the cocaine hit is longer. But the speed of the reaction to "crack" is phenomenal; when crack is smoked, the hit takes effect within 8 to 10 seconds, compared to the one to three minutes it takes for cocaine to take effect. Purity of the drug is another feature; common street cocaine is only about 15 to 25% pure and it is always mixed with a cutting agent, but "crack" is never mixed and is about 90% pure. On average, cocaine users snort or shoot two or three $10 bags of the drug during one session, while "crack" users vaporize and ingest five or more $10 vials in a session.

In addition, buyers of cocaine must examine their drugs before purchase, and the way cocaine is packaged---foil or paper packets---makes this difficult and somewhat risky. "Crack" users, on the other hand, may examine the goods by looking into the glass or plastic vial, and the package need not be opened before purchase. While "crack" seems somewhat less convenient than ordinary cocaine in use, it is apparent that the intensity and speed of the euphoric effect overcomes this for most users. My department estimates that more than half the cocaine traffic in the city involves "crack" thus indicating the popularity of the drug, despite any inconvenience in the use of the material.

But who are the "crack" users ?

Many younger persons are using "crack". Although the majority of sellers and buyers appear to be young adults---between 20 and 35 years of age---many more teenagers are buying "crack", and children as young as 10 or 11 are being introduced to the drug by older siblings and friends, who encourage them to take a puff or two from loaded cigarettes. Since cigarettes are both socially acceptable and legal, it is believed by many that normally cautious youngsters who would not take or swallow a pill or use a needle would not hesitate to take a puff from an offered cigarette laced with "crack".

Some "crack" users believe that the drug acts as a sexual stimulant and even as an aphrodisiac. Boys give "crack" to girls and girls accept the "crack" believing this.

"Crack", of course, was not invented in New York City. It made its first appearance as long ago as 1981 in Los Angeles, California and has since appeared on both coasts and in Chicago, Detroit and other urban centers. The federal Drug Enforcement Administration reports finding it in the Bronx, N.Y. in 1984, and the New York City Police Department laboratory was first presented with it to analyze in January of 1985. Crack is now available in all five boroughs of the city, as well as in suburban Westchester and Nassau Counties in New York State, and in various upstate New York areas, Connecticut, Delaware and Massachusets. Since "crack" is found in many parts of the United States, it can hardly be viewed as a purely local phenomenon. And it is obvious that the coca leaf---the raw material of cocaine and thus also of "crack"---is not grown in either New York City or the United States and thus must be imported across our borders in various ways. Two major coca leaf growing areas are Columbia and Bolivia, in South America.

"Crack houses"---locations where the drug may be used--- are springing up everywhere in the city and are similar to the old "shooting galleries" formerly used by heroin addicts. They are often in empty or abandoned buildings and are dirty and run down.

So much for the frightening and tragic basics of the new plague, "crack".

What is the New York City Police Department doing about the new plague ? Quite a bit, although the seriousness and the true dimensions of the problem are only now becoming clear. On May 21st. of this year, Police Commissioner Benjamin Ward and the Mayor of the City of New York, Edward Koch announced the formation and activation of a special Anti-Crack Unit, which is now in operation. It consists of 101 hand-picked members of the Department's Narcotics Division headed by a Deputy Inspector. The special unit targets the "crack" trade in the city. A special concern has been to identify, locate and supress the "crack" houses and to make arrests of sellers of "crack". As of June 22, 303 individuals have been arrested, 11 "crack" houses have been located and supressed, and a "crack" factory has been closed. Most of the individuals arrested were charged with felony sale of the drug. The special unit has also siezed more than seventeen hundred vials of "crack", 174 tins of cocaine, 235 pounds of marijuana and a variety of other narcotics-related materials, in addition to about $22,000 in U.S. Currency. This program is less than two months old, and its story is just beginning.

Indications of the dimensions of the "crack" plague are beginning to make themselves known, however. The Police Laboratory began recording analyses of "crack" seperately on May 18th. of this year. From May 18th. through May 31, 1986, a total of 1105 cocaine analyses were performed by the Laboratory city-wide, and of those 1105 analyses, 752 (68%) involved "crack".

While the arrest rate for cocaine related crimes increased during the first five months of the current year (up 57% over the same period in 1985), it is noteworthy that during that same five-month period this year, arrests for heroin and marijuana abuse related crimes DECREASED significantly. It is easy to conclude that both cocaine and "crack" are abundant and are now the drug of choice wherever illegal drugs are available on the streets of the City of New York, as elsewhere.

Since the beginning of 1986, overall, there have been 1,056 "crack"-related arrests in the City of New York as of the end of May. Many more such arrests are anticipated, of course.

It is apparant also, that complaints, arrests and other enforcement considerations will increase as time goes on. From May 21st. to June 5th. of this year, our Organized Crime Control Bureau (parent command of the Narcotics Division) received more than 2,900 drug-related complaints from all sources; more than 1,200 of those complaints---about 42%---involved "crack".

For those Members of the House who are not fully aware of the SPECDA program in New York City, let me outline briefly what it is and how it works. SPECDA stands for School Program to Educate and Control Drug Abuse.

It is a two-pronged effort---enforcement and education---and is a major cooperative effort between the New York City Board of Education and the Police Department. I believe it is the largest such effort between two components of City government. Begun at the start of the school year, in September, 1984, its goal is to reduce and if possible eliminate the sale of drugs in the area of New York City schools, and simultaneously, to make young school-age children aware of the dangers of drugs.

The enforcement effort is run directly by the Narcotics Division of the Department's Organized Crime Control Bureau. The main focus of this effort is the apprehension and arrest of drug sellers operating within a two-block radius of city schools, and the closing of so-called "smoke shops" within the same areas. Plainclothes and uniformed police officers are heavily engaged in this aspect of SPECDA.

The enforcement mode has targetted hundreds of city schools and the surrounding areas and there have been many thousands of arrests for sale---of which nearly 60 per cent have been felony charges. At the start of the recent school term, 63 per cent of the arrests were made in the vicinity of elementary schools, and interestingly only about 4 per cent of those arrested were students, while 78 per cent were over 20 years of age. More than a million dollars in narcotics were seized up till then, more than a third of a million dollars in cash, and about 80 firearms were also taken by the Police.

The educational component, however, is where the hope really lies for the future. If, as Commissioner Ward said here last year, the best effort should be placed in reducing or eliminating the potential drug market---regardless of the high number of arrests and convictions made now---then SPECDA's efforts in the schools among school-age children and young people is a major weapon and should be considered fully.

The goals of the SPECDA educational program were carefully worked out by the Police Department and the Board of Education together. It is critical that this kind of cooperative effort begin at the very conceptual stage and that the cooperation continue through the planning, training and execution stages. It cannot be done well, otherwise. SPECDA's goals, therefore, are the joint product of two city agencies working hand in glove. The goals, then are:

1. To alter constructively the attitudes and perceptions of young people pertaining to drug abuse;
2. To increase student awareness of the effects and consequences of drug and substance abuse;
3. To build a foundation for a constructive, ongoing dialogue between police officers and young people; and
4. To expand a cooperative, educationally constructive relationship between the New York City Board of Education and the New York City Police Department.

The overall goal is clearly to reduce the likelihood of drug usage among the student population by focussing on younger students who are assumed less likely to be current drug users. The target population was students in grades 5 and 6 who are, at that point in their lives, beginning to form their attitudes toward drugs and drug abuse, and who are first coming under pressure from peers and others to try drugs. It is a highly critical stage for these youngsters, and it was deemed by educational and police experts to be the best place to focus our major effort.

The Elementary School Education program lasts 16 weeks. All fifth and sixth grade students in the targetted schools receive 16 sessions of 45-minute duration---8 sessions in the fifth grade, and another 8 sessions in the sixth grade. The same team of hand-picked Police Officers and Detectives with Board of Education drug counselors works with both grades over the two academic year period.

There are two seperate curricula for fifth and sixth grades, but the focus remains the same in both, including a brief introduction to SPECDA, self-awareness to develop a sense of identity and positive self-image, discussions of peer pressure and its influence on behavior, strategies for resisting peer pressure, development of decision-making strategies and learning to "say NO to drugs", the pharmacology of drugs and their use and how the various drugs can wreck a human body, the social consequences of drug abuse, the psychological consequences of drug abuse, ways to develop leadership and positive alternatives to drug use, and a summary of the program and the presentation of awards to students upon completion of the course. These specially-developed publications were partially funded by the New York City Youth Board, by the way. At the end of the total 16-week program, each student has a complete set of written material as well any notes he or she might have taken during the course. In addition, the complete curriculum package is also presented to the school as a permanent library resouce for future use.

The SPECDA teams make presentations three days a week in the fifth and sixth grades, and on other days, a district assembly program is also presented to kindergarten through fourth grade, and another similar program is presented to participating junior high schools. This is a two-hour presentation.

SPECDA also recognizes the deep importance of the family in forming attitudes and controlling behavior in these youngsters. With this in mind SPECDA conducts an evening workshop program for parents led by the same instructors who reach out to the students. The aim of this is to inform parents about drugs and drug abuse, to inform them about the SPECDA schoolroom program, and to reach out for their help in reinforcing the SPECDA message.

Additional activity of SPECDA includes an assembly program on the dangers of drug abuse presented to students in non-target schools and districts which do not participate in the 16-week SPECDA classroom program. This assembly program is targetted specifically on elementary, junior high or high school levels and taught by specialized SPECDA teams. All modern presentation techniques are used, including speakers, slides, films and a mixed media package. Following the assembly programs, the students are divided into working groups to give them the chance to explore the discussion material in detail. Where appropriate, students are referred to drug counselors and other social services. It is estimated that during a typical month of these assemply programs, approximately 15,000 students are reached.

As an indicator of the quantitative and qualitative value of the SPECDA schoolroom and assembly program, the Criminal Justice Center of John Jay College of Criminal Justice of the City University of New York evaluated SPECDA and commented that "SPECDA appears to be a program delivered at the right time, in the right place, to the right people". That is high praise indeed!

SPECDA now operates in 154 elementary schools on the classroom level with the 16-week curriculum; there are 623 elementary schools in the City system. It currently operates in 7 of the City's 32 school districts.

The New York City Police Department, working in close cooperation with New York City Board of Education, through the various SPECDA programs during the recently ended academic year reached a total of 256,994 school-age youngsters.

We deem the School Program to Educate and Control Drug Abuse --SPECDA-- to be an unqualified success. The children who are reached----a quarter of a million of them last year----are informed about drugs, they respond to the information in a positive fashion, and there is good reason to hope that they will avoid the horrors and debasement of a life of drug abuse. I do not hesitate to say that the New York City Police Department has planted the seeds of hope with SPECDA.

The enforcement arm of SPECDA, I might add, during the month of May just passed, made 173 cocaine-related arrests within two city blocks of public schools, and of those, 127 (about 72%) involved "crack".

On the legislative level, the New York City Police Department has vigorously recommended an amendment to the state penal law pertaining to "crack" sales and possession. The recommended legislation would enable more and higher quality arrests for trafficking in "crack" by lowering the "felony weight" requirements for "crack" sellers and users. That will take some time to get enacted. Once the State of New York singles out and creates a special "crack" category perhaps the conviction rate for "crack" trafficking will increase.

It is of interest, also, that the Narcotics Division of the Police Department is now producing a training video on "crack" use and on strategies and tactics for enforcement for our enforcement personnel. They----and of course, We-----consider "crack" alone enough of a problem to justify this kind of special attention. The Narcotics Division has a Special Projects Unit which also provides information and lecture services to other police agencies and to the private sector; their material now includes special material on "crack".

In addition, the Narcotics Division has also estabilished a close working relationship with various State agencies concerned with "crack", including information exchange programs, data collection and other information.

And, as you undoubtedly know, the Commanding Officer of the Narcotics Division is the Department's representative to Representative Rangel's Ad Hoc Drug Enforcement Committee.

The New York City Police Department's concern for and involvement in matters related to the "crack" plague should be manifest to all. While the drug problem is the city is neither recent, nor small, the Department's many programs have all been effective to one degree or another. In January of 1984, under the leadership of Police Commissioner Ward, the Department's enforcement efforts-----Operation Pressure Point, on the lower East Side of Manhattan, Operation Pressure Point II, begun in March of the same year in Harlem, and Operation Clean Heights begun earlier this year in the Washington Heights section of Manhattan----have all been aimed at supression of the drug trade on the street level particularly. Similar related efforts on the local and community level have all been effective to a degree. Local targetted programs have resulted in thousands of arrests for narcotics related crimes and violations.

But, as Commissioner Ward noted before this Committee on November of 1985:

"I am not satisfied with making thousands of arrests .... I firmly believe that we must also try to cut down the demand for drugs".

At that time, the Police Commissioner noted with some satisfaction the cooperation between federal and State law enforcement officials, and the New York City Police Department in this area. I certainly add my voice to his in that regard.

But, I would also like to add my voice to Representative Rangel's eloquent letter to the New York Times last Friday and respectfully join him in calling attention to the fact that the cocoa plant does not grow in New York City. "Crack" fumes may indeed end up in the brain of some New Yorkers, but the root of the plant is elsewhere----beyond the reach of the New York City Police Department. I believe that the real answer is at the Federal level.

Thank You

"CRACK" COCAINE
A NATIONAL PROBLEM

"A Report From The Frontlines"

Presented To:

U.S. House of Representatives

Select Committee on
Children, Youth and Families and Select Committee on
Narcotic Abuse and Control

By:

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Commanding Officer
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Detroit Police Department

Tuesday, July 15,1986
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INTRODUCTION

The Detroit metropolitan area is ranked number six in the nation among large metropolitan areas. The Detroit/Wayne County population of 2.4 million people represents 25 percent of Michigan's total population. Combined with the two adjoining counties, Southeastern Michigan is composed of more than 4 million residents or about 44 percent of the state's population.

The City of Detroit is located on an international border, with Windsor, Canada only a five minute drive across the Ambassador bridge. This report concerns a national threat not from our neighbor to the north, but a threat crossing a border over 2,000 miles away.

Cocaine, Heroin and Marijuana, are as common on the streets of metropolitan Detroit as they are in those far away countries in which they are grown.

How these drugs reach the streets of the city is not the subject of this report. The effect they have on the quality of life of the citizens of this great city, is nothing short of a national disgrace.

It is my hope and belief, that as the Select Committee come to understand the "crack" cocaine crisis, they will reach the same conclusion that I have; "The future of a whole generation of Americans may depend on these hearings."

SCOPE OF THE PROBLEM

Eight months ago, the Detroit Police Department, Narcotic Section, had never heard of "crack" cocaine. It first appeared in Los Angeles and Miami in 1984 and more recently in New York and New Jersey as well as Detroit and other cities. Today, it is the major drug of abuse in most major urban areas.

"Crack" is a white coagulated powder resembling slivers of soap in appearance and is manufactured by coverting cocaine hydrochloride back to base, using baking soda and water. This simple process can be done in any home kitchen. It is important to note that "crack" is not imported into the country but is a product of the cocaine traffic.

The risk to the user of becoming addicted to cocaine is ranked most closely with how the user administers the drug, or how it is consumed. Smoking high potency cocaine carries the greatest risk of becoming addicted. "Crack" is consumed by smoking. The drug is sold in pellets which sells for about $20 each. The average dose, about 125 milligrams, is either smoked in a pipe, or crumbled into tobacco or marijuana cigarettes.

Due to the highly addictive nature of "crack" cocaine, it is not uncommon to find young people (13 - 15 years of age) with a $50 per day cocaine habit. It has been estimated that a $50 per day drug habit would require for the 365 day year, $18,250. ($50 x 365 days = $18,250.00) It must be understood that a $50 per day drug habit is a minor addiction.

The major method of distribution in the City of Detroit and several other cities, is on street corners in broad daylight, using young teenage males as agents. This method of distribution gave rise to a major drug ring known as "Young Boys Inc."

"Young Boys inc." (YBI) became the status symbol of success for black teenage males on the streets of the City of Detroit. Members of this highly organized drug distribution organization, were paid $250 per day to sell drugs on high volume street corners. This method of drug distribution is a story in itself, and has become the major method of seling drugs using youth in the 13 to 16 year old age group.

"Crack" cocaine has, in the short time it has been on the market created problems which has never before been a concern of law enforcement officials. These problems have required that a new and intervative approach be developed. These new problem areas include the following:

1. BREAKDOWN OF THE JUVENILE JUSTICE SYSTEM

The Juvenile Justice System was never intended to handle 14 - 16 year old hardened criminals. The youth involved in the "crack" cocaine business are not just your typical joy-riding car thief. These kids are gun carrying criminals who will kill to protect their individual street corners.

These criminals know full well how the system works and will use it against attempts to police a high volume street corner. Indeed, that is why they are involved in the first place. It is hard for a police officer to see major actors in a drug operation walk out of jail with a minor ordinance ticket. They laugh at us, and they laugh at those members of the Select Committee who still think there is no such thing as a "bad boy."

This procedure produces adult criminals who have no respect for the Criminal Justice System.

2. ROLE MODEL CRIMINALS

The "crack" cocaine crisis has produced negative role models for the youth of this nation. Ask a inner city black youth what he wants to be in the future, and don't be surpised if he says, "a major drug dealer."

When a youth in the inner cities look round, he does not see a doctor, lawyer, or a businessman, what he sees is the dope dealer in a new car and spending large amounts of money.

How do we tell a young kid to stay in school and work in the "Burger King" for $3 a hour, when he can make $250 a day selling "crack!"

Detroit has a 40% dropout rate between the 9th and 12th grade of high school. These kids have made a decision to live in the fast lane and die there, and when life becomes too hard, just take some "crack."

3. DRUGS AND CRIME

The National Institute of Justice in its February 1985 report on "Research in Brief" stated that, "one-quarter or more of homicides, 75 percent of all robberies, and 50 percent of all felony assaults were committed by pill or cocaine/heroin users." Does this nation have a crime problem, or do we have a drug problem?

The major problem with "crack" cocaine is that young people must become involved with criminal activity just to consume the drug. Once a youth starts down a path of criminal activity, there is no way to reverse that trend.

In Detroit, most drug "pads" usually have stolen property on the premsies. This would indicate that youth are breaking into homes and businesses to steal property to exchange for "crack".

More important than the amount of actual crime, is the fear that this drug is created within the neighborhood.

There is a clear statement made when drive down a street and see bars on the windows and doors of homes and attack dogs in every yard.

The youth-on-youth crime that is a direct result of the "crack" crisis has changed the way americans deal with each other. No longer will people have large numbers of youth in their homes for a teenage function.

We as a nation has accepted the role of drugs in our society and therefore the youth of the nation is living out the expectation.

RECOMMENDATIONS

The following recommendations are made based on many years of dealing with the national drug problem at the street enforcement level.

1. The juvenile justice system must be changed to reflect the difference between youth involved in minor criminal behavior and hardened felons who happen to be young. The best chance we have to change criminal behavior is with the first contact, rather than using a revolving door policy that produces a disrespect for the criminal justice system.

2. The federal government must take whatever steps are necessary to stop the production of cocaine in the source country. It is much easier to police the problem while the drug is in bulk form, than it is to try and stop hundreds of thousands of small packages.

3. The Select Committee should recognize that the narcotic trafficking in the country is a major business. The Federal Forfeiture Law is the most effective tool in fighting this problem.

All assets removed from major drug dealers should be used for substance abuse programs, and not placed in the general fund.

4. In Detroit, we have a long history of neighborhood involvement by community organizations and individual citizens. The volunteers are there and the vehicle to get the job done exists. What is needed in this war is a rally point for all segments of our society to gather around. The churches, schools, families, criminal justice and neighborhoods all have a part to play. F.A.D. "Families Against Dope" with training and prevention as goals, would need national, state and local support to begin to make inroads against this problem.

5. There is a supply side and a demand side to the "crack" cocaine problem. It would do little good to completely stop the flow of cocaine, and not address the growing number of cocaine addicts. Therefore, there should be a drug education program in every school directed at the kindergarten through the 9th grade students.

This recommendation, if adopted in part or in total, should have the desired effect of reducing the present drug crisis.

CONCLUSION

There are no quick and simple answers to the drug abuse problem among the nation's youth. It will take nothing less than a total commitment from all segments of society. Unless, we are willing to make that commitment, we are in a war that can not be won.

Supportive Documentations

DRUG ABUSE TREND UPDATE
DETROIT/WAYNE COUNTY, MICHIGAN

December, 1985

Reference:
Community Epidemiology
Work Group Report
National Institute on
Drug Abuse
Miami, Florida
December 10-13, 1985

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DRUG ABUSE TREND UPDATE
DETROIT/WAYNE COUNTY, MICHIGAN
December, 1985

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Introduction

The Detroit/Wayne County population of 2.4 million people represents 26% of Michigan's total population. Combined with the two adjoining counties, southeastern Michigan is composed of more than four million residents, or about 44% of the state population. However, the metropolitan Detroit area population has declined 3.7 percent since 1980. The Detroit area was the only one of the 10 largest urban areas in the U.S. to experience a decline, yet Detroit remains ranked number six in large metropolitan areas. The data reflected in this report is relevant only to Detroit/Wayne County, although some parallels are drawn to statewide data.

This report reflects the use of a variety of information sources as cited in prior reports.

Heroin

Heroin continues to be the major focus of law enforcement activity in narcotics for the Detroit/Wayne County area, although cocaine continues to increase across all indicators. Police activity continues to shift to more cocaine targeting.

The Drug Enforcement Administration's Domestic Monitor Program is a retail level (i.e. street level) heroin sampling program intended to provide information regarding availability, price, purity, adulterants and other information for several major metropolitan areas. Detroit has been a target city since 1981 for this effort. An average of 10 samples a month are obtained in different areas of the local geography. The DEA conducts tests with the Heroin Signature Methodology to identify origin. Reports were produced on a quarterly basis through 1983; in 1984 these were produced on a semi-annual basis and in 1985 the entire Monitor Program experienced changes and reductions due to funding problems and differing administrative priorities. The data cited herein are unofficial and preliminary, and it should be noted that trend analysis is made more difficult when reporting systems undergo major changes. It is also important to note that the number of samples tested in 1985 has been much fewer than previously, and the reader is cautioned about making conclusions based on a small number of observations.

The average heroin purity as reflected in the DEA Monitor Program was 1.9% through the first six months of 1985 as compared to 2.5% for the July thru December, 1984 period (see Table 1). The 1984 (last six months) data represented a slight increase (9%) from the 2.3% average in the prior six month period, but a substantial decline from 1983 (i.e. purity fell to almost two-thirds of that in 1983). The current 1.9% purity is the second lowest since the Monitor Program began in Detroit.

The range in purity across samples has shown considerable variation in the past. Samples of high purity are excluded in calculation of average purity (as are samples containing no heroin at all); during the latest period two samples containing high purity (26 and 31 percent respectively) were not included in the calculations.

The DEA Monitor Program also provides data on average price of heroin (as based on 100% purity). The June, 1983 report noted an apparent sharply increasing trend in average price/pure mg. during the period from April, 1983 thru March, 1984. In fact the average price would appear to have tripled between the October, 1982 and October, 1983 quarters. However, the average price for the period January thru June, 1984 was $2.90; while the data for July thru December, 1984 showed an average price of $3.36 per pure milligram. The 1985 data (January through June) shows $3.09 per pure milligram; (a 13% increase in price over 1983). The overall trend in price seems relatively stable. This may reflect an increased demand for heroin or it may be more a factor of the ongoing competition for the market by dealers. It is also believed to be influenced by changes in the distribution channels.

The DEA Signature Analysis procedure allows for identification of place of origin of the heroin samples. The majority of the heroin in the Detroit area has traditionally originated in the Middle East: Turkey, Pakistan, Italy and Lebanon. In fact, nine of the eleven samples in 1985 were from the Middle East; one was from SouthEast Asia and one could not be identified as to it's source. Heroin of South East Asian origin represented 31% of the samples for July thru December, 1984; this compares to 22% during January thru June, 1984. Mexican heroin (brown color) represented seven percent of the samples in 1983, while in the July thru December, 1984 period Mexican heroin accounted for 28% of the samples. Mexican heroin in the Detroit area has not been significantly found since the mid 1970's (although the Michigan State Police reports that Mexican heroin is routinely found in out-state areas such as Saginaw and Muskegon which have substantial populations of Hispanic origin). It remains to be seen whether this change in source of heroin is confirmed over time. Some of the Mexican heroin is in "brown gummy balls" of high purity which reportedly are first frozen and then diluted in a blender. There were no samples of Mexican heroin in the 1985 Monitor samples, but there are indications from other samples that Mexican heroin is available in the Detroit area.

Other information from the most recent DEA Monitor samples continues to reflect adulterants (or "cuts") of lactose, mannitol and diphenhydramine. Samples were packaged primarily in manila packets and coin envelopes.

The Detroit Police Narcotics Unit continues to focus on heroin although increasing cocaine arrests reflect increased cocaine use and trafficking in the city. The proportion of cases processed to court for heroin has remained at 55-58% since 1980; 1985 is the first time where heroin cases were less than half of the total cases processed to court (see Table 2). In fact, the proportion of total cases to court for heroin thus far in 1985 is 42% as compared to 52% in 1984. This is a decline of about one-fifth in a year's time. However, the absolute number of heroin cases (496 for the first nine months of 1985) would appear to be down almost 25% on an annual basis from 1984; the 1984 heroin total cases were also down by 44% over 1983. This is believed to be influenced in part by difficulties in penetrating the "new organizations" which sought the market after the arrests of the "Young Boys, Inc.", the "Davis Family Group", and the "Pony Down Gang" in 1982, 1983, and 1985 as well as the large increases in cocaine activity. (Several more homicides have occurred in attempts to control the market from prison on the part of "Young Boys, Inc." former leaders). There is also some feeling that since the federal Drug Enforcement Administration continues to primarily target heroin, the Detroit Narcotics efforts can thus focus more on the increasing cocaine trafficking.

Also of significant note is what continues to be a fundamental change in the "marketing" of drugs. Heroin is now much more often sold "on the street" vs. the traditional method of obtaining it in "shooting galleries". Cocaine, on the other hand, is frequently sold in "coke houses" because of the complicated equipment involved in the "free base" method of administration.

Heroin confiscations by the Detroit Police Narcotics Unit were over six pounds thus far in 1985 compared to over 10 pounds in 1984 and over 15 pounds for 1983. However, some morphine was seized in both 1984 and 1985 (none in 1983).

Young persons under 20 years of age continue to represent over one of every four persons arrested by the Detroit Police Narcotics Unit. In past reports it was noted almost half of those arrested are not confirmed as drug users themselves based on admittance, denial, observation of physical signs, or withdrawal symptoms. However, during September 1985 just under 40% of all arrestees could not be confirmed as drug users. Some of this change is attributed to an apparent increase in arrestees' willingness to admit drug use because of a perceived very low likelihood that processing the arrest through the Criminal Justice System will result in jail time.

The Detroit area section of the Michigan State Police Narcotics Unit arrested 22 individuals for heroin thus far in 1985 (nine months); 23 in the same period during 1984. The "out-state" section arrested another 16 individuals for heroin, all but one were for delivery.

The Wayne County Medical Examiner has been analyzing cases specific to drug abuse and narcotics involvement since 1974.

The data available through October, 1985 (191 narcotics deaths) suggest that narcotic deaths in 1985 may exceed the 1976 level of 206 such deaths (see Table 3). Since that time (particularly in the 1980-1984 period these deaths were relatively stable at 141-192) deaths had declined or increased then stabilized.

The Drug Abuse Warning Network (DAWN), as operated by the National Institute on Drug Abuse (NIDA), provides another indicator on drug usage trends over time. Drug abuse involvement in hospital emergency room visits to major metropolitan area hospitals are collected and summarized through DAWN.

The most recent DAWN data available for the Detroit area is for the last 36 months through June, 1985 (see Table 4). In the last six months of 1982 there was an average of 680 heroin mentions per quarter, while in 1983 there was a quarterly average of 823 such mentions, or a 21% increase over the one year period. During 1984, heroin mentions averaged 632 per quarter. This represented a 23% decline over 1983 and a seven percent decrease over 1982. In 1985 thus far there were 701 heroin mentions on the average each quarter; this is an 11% increase over 1984. The April-June, 1985 quarter was particularly high with 825 heroin mentions. This apparent "jump" is paralleled somewhat by an increase in narcotics deaths in this same period as reported by the Wayne County Medical Examiner. This changing pattern is believed to be strongly influenced by the vigorous law enforcement actions during 1983 which resulted in disruptions of the major heroin distribution networks. It is also important to note that changes continue to occur within the hospital care network in the Detroit area particularly in terms of treatment for indigents. Future data on DAWN may be effected by this occurrence as well as by the recent implementation of the Diagnosis Related Group (DRG) payment systems for hospital care by the state Medicaid Authority.

Treatment admissions to Detroit/Wayne County programs have been averaging about 4200 cases per quarter since 1980; however in FY 1983/84 there were almost 4600 admissions per quarter (see Table 5). In FY 1984/85 there were an average of 4423 admissions per quarter.

The proportion of total Detroit/Wayne County treatment admissions which involved heroin as the primary drug seems to be declining; was 24% in FY 1982/83 and 23% of all admissions in FY 1983/84 (see Table 6). In FY 1984/85 heroin represents 20% of total admissions. (However, the proportion of admissions reporting cocaine almost tripled during FY 1984/85. This will be discussed later in this report). The absolute number of heroin admissions was 3410 in FY 1984/85, or a 19% decrease over the prior year.

Almost half of Detroit/Wayne County heroin admissions (44%) were between 30-35 years old during FY 1983/84, as well as in FY 1984/85. The 26-29 year old group made up 21% (down from 23% last year) while the 36-44 age group increased from 19% to 22% in FY 1984/85 heroin admissions. Eight percent were aged 21-25 while one percent were less than age 21 at admission. Overall, the age distribution seems remarkably stable.

Three of every four heroin admissions in Detroit/Wayne County during FY 1983/84 were Blacks while 24% are Whites. Over two-thirds (68%) are males. These figures are also virtually stable.

Data on employment status among heroin admissions shows that 14% were employed full time while 76% were unemployed yet in the work force during FY 1984/85. This represents a two percent decline from the FY 1983/84 data for those reporting to be employed full time.

Prior reports noted that the age of first use of heroin among admissions was under 21 years of age for about two of every three admissions. This trend is also reflected in admissions during FY 1984/85. About three of every ten heroin admissions began use between 14 and 17 years of age (31%) and a similar proportion began between 18 and 20 years of age (30%). Four percent reportedly began at age 13 or younger.

There is a considerable "lag period" between the year of first use of heroin and admission to treatment. As noted in the prior reports, the largest group (63%) of heroin admissions began during the period between 1965 and 1974 (see Table 7). Just over one in four (27%) admissions began since 1975 and 10% began since 1980. These figures are consistent across the past four fiscal years admissions data. The data also show that 10-11% of admissions use heroin for five years or less before entering treatment. Another 19-29% use heroin between six to ten years before entering treatment, while one-third to one-half of admissions each year have used heroin for between 11 and 15 years before entering treatment. It would therefore seem reasonable to state that heroin seems to be largely concentrated in an age cohort which began their use between 1965 and 1974 and who are now between 30 and 44 years old.

Three of every four heroin admissions to Detroit/Wayne County programs live in the city of Detroit.

Just under half (45%) of heroin admissions reported no secondary drug use; this compares to 52% last year. Alcohol (32%), cocaine (28%) and other opiates (28%) were the most common secondary drugs.

In FY 1984/85, the vast majority of those using heroin at admission reported daily use (88%). Another four percent reported almost everyday use patterns while three percent reported what is a "weekends only" use pattern.

Cocaine

Cocaine continues to be increasing across all indicators for the Detroit/Wayne County area, as well as in Michigan as a whole.

The Detroit Police Narcotics Unit made 343 arrests for cocaine through September 1985; at this rate there will be twice as many cocaine arrests over 1984. Cocaine was the second most frequent drug in total arrests by Detroit Narcotics officers during both 1984 and thus far into 1985. In 1985 cocaine arrests are almost a third of all narcotics arrests made by the City of Detroit Narcotics Unit. Previous to 1984, cocaine ranked third after heroin and marijuana. Larger amounts are more frequently encountered. The Detroit Narcotics confiscated over 17 pounds of cocaine during 1984 as compared to over six pounds during 1983; in 1985 thus far over 11 pounds of cocaine have been seized.

A new indicator of drug trends may be "raids statistics" now being kept by the City of Detroit Police Narcotics Unit. In 1985 there have been an average of three and one-half "raids" made per day, in 53% of these instances cocaine was primarily involved compared to 17% heroin and 19% marijuana. This suggests a much broader availibility of cocaine in that these raids took place in all areas of the City of Detroit while heroin was more confined to certain locations.

Data from the Drug Abuse Warning Network (DAWN) in terms of emergency room mentions of cocaine are also showing an increase. During the last six months of 1982 there were an average of 72 cocaine mentions each quarter; during 1983 there were 122 mentions. This was an average increase of nearly 70%. During 1984 there were an average of 148 cocaine mentions per quarter; this was a 21% increase over 1983. Through June of 1985 there were a quarterly average of 211 cocaine mentions; this is an average increase of 43% over 1984 levels. Over the entire three year period cocaine mentions almost tripled on an average quarterly basis.

The Wayne County Medical Examiner reports that several deaths involving probable cocaine overdose have occurred in 1985; at least one was a "free-base" user. Cocaine is increasingly appearing in homicide victims. In May, 1985 there was cocaine in four of 68 homicide victims; overall seven cases had various combinations of opiates, alcohol, quinine, cocaine and PCP in their systems. In June 1985 six of 59 homicide victims had drugs in their systems; three tested cocaine positive. The Medical Examiner estimates that more than 10% of all homicide victims now test positive for cocaine. Overall, homicides in Detroit have increased 19% since last year, while the total number of serious crimes decreased by six percent.

During 1984 Michigan State Police Narcotics officers arrested 700 persons on cocaine charges (at least 90% for delivery/sales). This level is nearly identical to 1983 activity. Through September of 1985 Michigan State Police have made 531 cocaine arrests (this is a 16% increase over last year). The Michigan State Police estimates that 75% of their narcotics investigation resources are now involved in cocaine.

Virtually all reports note that cocaine continues to be readily available in the Detroit/Wayne County area and it is often of high purity (80-90%). Similar reports suggest increased availability throughout the state. Street-level purity (usually is gram volumes at $100-125) seems to be generally 30-50% purity according to some reports.

Admissions to treatment for primary substance abuse problems with cocaine are increasing sharply in Detroit/Wayne County as well as in Michigan as a whole. For the state as a whole, the number of admissions in FY 1982/83 was 446; this compares to 799 in FY 1983/84. In FY 1984/85 there have been 2156 cocaine admissions. This trend appears to be increasing by at least doubling each year. For Detroit/Wayne County, the number of cocaine admissions in FY 1982/83 was 187 versus 473 in FY 1983/84. In Detroit/Wayne County there have been 1262 cocaine admissions in FY 1984/85; this represents more than twice as many cocaine admissions over the prior year. The Detroit/Wayne County area accounted for 60% of statewide cocaine admissions in FY 1983/84, while in FY 1984/85 this proportion was 59%.

In terms of frequency of use at admission, during FY 1984/85 almost two-thirds (65%) of the Detroit/Wayne County admissions who used cocaine in the prior 30 days reported daily use patterns. On a statewide basis 38% were daily users. This represents a proportional increase in daily users in FY 1984/85 in Detroit/Wayne County but a decrease on a statewide basis. In Detroit/Wayne County 10% used cocaine on a four to six days per week basis while statewide this use pattern was reported by nine percent of cocaine users. These are decreases over FY 1983/84 (18%). In Detroit/Wayne County 12% of cocaine admissions reported a "weekends only" use pattern (same percentage statewide). These are also decreases over FY 1983/84 data. Overall, cocaine users admitted in Detroit/Wayne County seem to be using the drug much more frequently than outstate admissions.

Cocaine admissions continue to be largely concentrated (81%) in the 21-35 year old age group in both Detroit/Wayne County and Michigan. The 21-25 year old group made up 24% of Detroit/Wayne County admissions while the 26-29 year old group represented 26% and the 30-35 year old group represented 31% of Detroit/Wayne County admissions.

Males continue to make up the majority of cocaine admissions; 74% in both Detroit/Wayne County and statewide.

In terms of race, cocaine admissions during FY 1984/85 in Detroit/Wayne County were 69% Blacks (63% in FY 1983/84) and 30% Whites (34% in FY 1983/84) with the remainder mostly Hispanics. There have now been four American Indian admissions for cocaine where there were none before. On a statewide basis 41% were Whites (51% in FY 1983/84), while 57% were Blacks (47% in FY 1983/84).

The proportion of Detroit/Wayne County cocaine admissions who were employed full-time was 25%; statewide this group was 36%. These are slight increases over last year. The unemployed in the work force group represented 70% of Detroit/Wayne County cocaine admissions while statewide the unemployed but able to work made up 52% of the cocaine admissions.

Over one in every three cocaine admissions (35%) in Detroit/Wayne County reported they did not use any secondary drugs; just under one in three (32%) of statewide admissions reported having no secondary drug use. These are nearly five percent increases over last year. Alcohol was the most common secondary drug (32%) for Detroit/Wayne County admissions in FY 1983/84; in FY 1984/85, alcohol is reported 41% of the time to be the secondary drug. Marijuana was the next most common secondary drug; 27% for Detroit/Wayne County cocaine admissions and 29% for statewide cocaine admissions. Heroin follows with 23% of the secondary drug reported in Detroit/Wayne County and 16% statewide.

Another indicator of the increase in cocaine is it's mention as a secondary drug. For Detroit/Wayne County admissions in FY 1984/85 cocaine was reported as the secondary drug in 1101 admissions; almost half of these reports of cocaine as secondary involved heroin as the primary drug while another 44% of the reports of cocaine as secondary drug involved primary alcohol problems. On a statewide basis in FY 1984/85 cocaine was reported as secondary drug in 1906 admissions; over half (51%) of these reports of cocaine as secondary involved alcohol as the primary drug while almost another 34% involved heroin as the primary drug.

There are apparently certain differences in Detroit/Wayne County between admissions for a primary cocaine problem and admissions for a secondary cocaine problem. Secondary drug cocaine admissions tend to be more often White (although Blacks dominate in both primary and secondary cocaine admissions), more frequently divorced or less frequently married or cohabitating. Also, admissions with secondary cocaine problems tend to be older at admission.

In terms of age of first use for cocaine admissions in FY 1984/85, the most common age range reported was between 21-25 years (29% statewide). The age period between 26-35 years was next most frequently reported (24% statewide) while the first use of cocaine was reported as occurring between 14 and 17 years of age by 17% of the statewide admissions.

One factor regarding year of first use of cocaine and subsequent admission to treatment (which has been consistent over the past four years) is that use occurs for about five years or less before entry into treatment for at least 50% of the admissions (see Tables 8 and 9). About another 25-30% use cocaine for between six and ten years before entering treatment. This pattern is quite similar to that for admissions with other opiate problems but very different from that for heroin admissions.

Also confirming the increases in other cocaine indicators are urine tests conducted on current and prospective treatment admissions in the City of Detroit. The percentage of tests indicating positive cocaine use was 7.3% in December, 1982; this rose to 13.5% in December, 1983 and to 25.8% by December, 1984. This percentage has continued to rise; in September and October 1985 over 39% of all tests were positive for cocaine. This cocaine data confirms the projections made in the last report wherein this percentage was expected to double on an annual basis. This trend is very similar to that of cocaine admissions which have doubled each year over the past two years. It is of some importance to note that during the 1985 period as cocaine increased in urine tests the percentage of positive tests for quinine and morphine has declined. The extent of this decline appears significant, in that during 1982-84 the percentage of positive morphine test results were near 30% while in September and October 1985 this percentage fell to 20-21%.

Cocaine continues to be commonly packaged in inner-city Detroit in "rocks" using heat-sealing plastic materials to separate each item. These packages cost $25 in the Detroit area and contain about one quarter of a gram. There are some reports on street availability of $10 quantities of cocaine particularly among teen-age populations in Detroit.

Other Opiates

Overall, opiate admissions to treatment are lower in 1984/85 than they were in the previous year (see Table 7). However, as noted in the last report, there are mixed indications that the abuse of opiates other than heroin is increasing in the Detroit/Wayne County area. These types of drug are manufactured synthetically; the most common drugs include demerol, dilaudid and codeine.

During 1984 the Detroit Narcotics Unit made 32 arrests for dilaudid; this is almost the same level as in 1983 (33 dilaudid arrests). Through September 1985 there were 14 dilaudid cases. Codeine arrests are increasing; there were 159 arrests in 1984 as compared to 173 in 1983. Figures for 1985 are parallel to 1983 data. Codeine is the fourth most common drug involved in arrest by Detroit Narcotics Unit; it's percentage of all arrests has increased over the past five years. The Detroit police seized 32% more codeine (7851 tablets) in 1984 than in 1983. The 1985 data through September shows 12,946 tablets seized; at this rate the annual total will double codeine seizures over 1984 levels. Also, thus far in 1985 the seizure of 1107 demerol tablets were reported vs. none in 1984.

Data for 1985 from the DAWN system seems to show a declining trend in quarterly average dilaudid, demerol and codeine mentions since 1982; during the most recent quarter (April-June 1985) there were 11 dilaudid mentions; in the quarter a year earlier there were 31 mentions. Mentions of codeine are slightly more stable, except that in the most recent quarter in 1985 there were 9 (vs. 14 mentions in the quarter a year earlier).

Michigan now (first quarter, 1985) ranks number five in per capita distribution of dilaudid (was number one in July 1983). Michigan is now number three per capita for codeine products (vs. number one in July 1983) based on the DEA s latest ARCOs data. Overall, the total grams purchased of Schedule 2 depressant drugs declined 45% between September of 1983 and September 1984. There was a similar two percent reduction in narcotic analgesics.

Pentazocine (talwin) and tripelennamine (pyribenzamine) continue to decline as noted in previous reports for Detroit/Wayne County. Detroit Narcotic records show that 13 talwin arrests occurred during 1984 as compared to 52 during 1983. There have been only two arrests for talwin through September of 1985. Seizures of talwin are also down; there were 1087 tabs seized through September 1985 (vs. 1724 tabs in 1984 and 2012 tabs during 1983).

The DAWN system also reflects the decline in talwin and pyribenzamine; the quarterly average talwin mentions were 38 during 1983. The 1984 level of nine talwin mentions per average quarter is about one-forth of that in the prior two years. Thus far in 1985 there have been only seven talwin mentions in six months of DAWN data.

During FY 1983/84 there were 26 admissions statewide with a primary drug problem of "T's and Blues"; 11 of these cases were in Detroit/Wayne County. During FY 1984/85 there have been 39 admissions statewide with eight in Detroit/Wayne County. Although this is an increase in admissions it is believed to be largely due to depletion of "supplies" of the "old version of Talwin" (i.e. not containing naltrexone) by long-term users.

In terms of treatment admissions, the number of admissions in Detroit/Wayne County for other opiates (N=693) was increasing by quarter during FY 1983/84. This appears now to be changing. In Detroit/Wayne County during FY 1984/85, annual admissions (N=535) for other opiates were down by about 23% compared to FY 1983/84.

In terms of age, 26-35 year olds represented 70% of all admissions for other opiates, over one in ten (11%) were between 21-25 years of age while two percent were less than age 21 in FY 1984/85.

Over half of the statewide admissions for other opiates and synthetics reported their year of first use to be within the last ten years (see Table 11).

Over six of every ten other opiate admissions were Whites while 37% were Blacks. Just over half (53%) were males. Over one-third (36%) of these admissions were to methadone maintenance programs while one in four (25%) entered residential treatment.

Almost half (41%) reported no secondary drug usage. For FY 1983/84 admissions, heroin was the most common secondary drug used (31%) followed by alcohol (21%); however, during FY 1984/85 alcohol is the most common secondary drug (35%) followed by heroin (24%). Over eight of every ten (84%) users reported daily use of other opiates at admission.

Amphetamines

Prior reports have noted that Michigan has ranked number one in per capita distribution of prescription methamphetamine (desoxyn). The DEA reported that although Michigan has only four percent of the United States population, it had accounted for over 36% of the nation's total methamphetamine distribution in 1983 and earlier. However, by the third quarter of calendar year 1984, Michigan accounted for 24% of the national total. By the first quarter of 1985 Michigan became ranked number three per capita. This reduction is due in part to increased awareness and more law enforcement and regulatory activity. The State Medical Board changed amphetamine prescription standards in 1984. Michigan now ranks number four in methylphenidate (ritalin) distribution (was number two in 1984 and number one earlier). It is believed that a substantial amount of these drugs are diverted to other areas of the United States and possibly even out of the country. Because of the huge volume of these substances it is suspected that it may be some time until other indicators (such as increased treatment admissions because of lack of availability) begin to show an impact of these actions.

Police arrests and seizures of amphetamines continue to be relatively small. The DAWN data also shows a relatively low level of methamphetamine and amphetamine mentions; the range over quarters in the last three years is zero to twenty mentions with a steady decreasing trend over time.

There were 114 admissions for amphetamine abuse in Detroit/Wayne County in FY 1983/84; this was about one-third of statewide admissions (N=367). In FY 1984/85 there were 80 amphetamine admissions in Detroit/Wayne County and 312 statewide. About half (54%) were males while 30% were between 26-29 years of age. Almost seven of ten are between 21 and 35 years of age. Over half (51%) entered outpatient treatment while 28% entered residential treatment. Three of four (75%) are Whites while 25% are Blacks. Compared to last year's admissions data, amphetamine admissions now involve more Blacks (23% in FY 1983/84) and fewer admissions to residential treatment (41% in FY 1983/84).

An investigation stemming from the PADS (Prescription Abuse Data Synthesis) effort sponsored by the American Medical Association and federal state and local law enforcement resulted in a conviction of an osteopath who was reportedly the nations number one professional purchaser of amphetamines. According to federal records, this individual purchased 2.5 million amphetamine and 600,000 ritalin tablets since October 1, 1980. Almost half were seized in the arrest.

Other Drugs

Although there are a wide variety of other drugs being abused in Detroit/Wayne County, there is not enough space available here to describe trends for all these drugs in much detail. However, some statements may be made regarding trends in certain drugs over the past several months.

As noted in the last report, quaaludes continue to decline; police data as well as DAWN and treatment admissions data suggest there are minimal levels of use and availability of this drug. In fact, the DEA reports that the amount of this drug prescribed decreased by 84 percent in Michigan between 1983 and 1984.

While valium continues to be the fourth most common drug mentioned in DAWN, overall mentions have been declining since 1982 at a rate of almost two per month (the quarterly average mentions are now about 100 over the last year).

Marijuana continues to be reflected at relatively stable levels in police reports as well as in other indicators. During the recent well-publicized national effort aimed at domestic growers there were a number of arrests and confiscations.

Among the 3051 statewide marijuana admissions in FY 1983/84, 761 (25%) were in Detroit/Wayne County. During FY 1984/85 there have been 3406 statewide and 647 admissions in Detroit/Wayne County for marijuana. Males represent almost three of four marijuana admissions and about the same proportion (71%) are Whites. Almost half (45%) were between 14-17 years old. About four of every ten marijuana admissions were daily users. Almost all (81%) entered outpatient treatment.

Detroit Narcotics Police report marijuana is now the third most common drug involved in arrests; it was second until 1984 when cocaine surpassed it.

Data from the DAWN system showed a 1984 quarterly average of 62 marijuana mentions; in the prior year (1983) there were an average of 191 mentions per quarter. In 1985 this far the quarterly average is 70 marijuana mentions reported through DAWN.

The Wayne County Medical Examiner reports that there have been 47 cases of non-narcotics drug-involved deaths in the first ten months of 1985. The frequent combination of alcohol with tricyclic antidepressants seems to be continuing; elavil, mellaril, doxepin, pentobarbital, librium and darvon were involved in these cases.

There were 44 PCP admissions during FY 1984/85 in Detroit/Wayne County while the statewide total was 64. During FY 1983/84 there were 93 PCP admissions statewide with 62 of these in Detroit/Wayne County. Over two-thirds entered outpatient drug free treatment programs. Almost all (89%) were Whites while 10% were Blacks.

There were 104 admissions for tranquilizers in Detroit/Wayne County and 242 statewide in FY 1983/84. During FY 1984/85 there were 197 admissions statewide with 70 of these occurring in Detroit/Wayne County. Among this group, almost two-thirds are females while 70% in Detroit/Wayne County and 80% statewide are Whites.

Just over one-third, (36 admissions) of the 100 statewide admissions for hallucinogens during FY 1984/85 occurred in Detroit/Wayne County. In FY 1983/84 there were 130 such admissions statewide with 53 in Detroit/Wayne County. Males accounted for 86% of these admissions.

Other Comments

There have been several reports regarding availability and use of so-called "designer drugs" in the Detroit area over the past several months. Although there has been some cases confirmed to have Parkinsonism (caused by taking certain of these drugs) the actual presence of these drugs has yet to be confirmed by finding a "valid sample". It is felt that locally developing the testing capability to identify these substances would be most helpful in preventing their spread once their presence is confirmed.

Over the past several months (in particular) there have been increased levels of violence on the part of teenagers in Detroit. A number of rather dramatic shootings have taken place, and there are a variety of sources which assign much of this violence to competition for drug trafficking "markets". There are many reports of the existence of street gangs which seek to control local areas (these seem to follow the "lead" of "Young Boys, Inc."). Since the last report, federal and local law enforcement has made a number of arrests among the "Pony Down" organization.

New strategies to disrupt adolescent drug trafficking organizations will be expanded shortly by the Detroit Police Narcotics Unit; these efforts will include the arresting of persons "hanging out" on street corners known to be sales areas.

Detroit Metropolitan airport has recently grown in it s volume of air traffic, and law enforcement reports note an increasing level of drug trafficking via the "swallowing of balloons filled with cocaine".

A federal investigation is now working in Michigan to identify banking institutions which violate federal law which requires reporting of cash transactions exceeding $10,000. Much of this kind of activity involves drug trafficking money.

The Michigan Attorney General is proposing legislation which would allow the electronic surveillance of major drug suspects. Also proposed are measures to toughen penalties for adults selling to juveniles and to grant immunity to adolescents who cooperate in investigations.

The existence of AIDS in Michigan has caused a great deal of recent media and public attention. Several cases are now confined to county jails and Jackson Prison. As of the end of September, 1985, there are 89 cases of AIDS confirmed (41 deaths have occurred within this total) seven of these cases have been noted as intravenous drug users.

TABLE 1

Heroin Price and Purity

(Source: Domestic Monitor Program, Drug Enforcement Administration)

	1981				1982				1983				1984*		1985**
	Jan Mar	Apr Jun	Jul Sep	Oct Dec	Jan Mar	Apr Jun	Jul Sep	Oct Dec	Jan Mar	Apr Jun	Jul Sep	Oct Dec	Jan Jun	Jul Dec	Jan Jun
Number of samples	20	26	30	29	27	30	33	25	19	19	22	26	57	37	11
Number of sample (no Heroin)	2	-	3	8	2	5	3	-	4	-	3	2	2	8	-
Average purity	4.8%	3.9%	4.9%	6.2%	2.8%	3.7%	3.2%	4.3%	6.1%	4.5%	3.9%	2.6%	2.3%	2.5%	1.9%
Purity range	.3% thru 23.0%	.9% thru 29.1%	.4% thru 53.2%	.2% thru 47.5%	.3% thru 39.2%	.1% thru 12.0%	.6% thru 13.0%	.3% thru 31.1%	.4% thru 31.8%	.9% thru 10.8%	1.1% thru 30.0%	.4% thru 22.8%	.01% thru 44.9%	.01% thru 15.9%	.34% thru 31.6%
Average price per sample	$213	$135	$129	$125	$82	$81	$98	$100	$106	$113	$97	$125	$102	$101	-
Average price per mg. (if pure)	$11.80	$5.74	$4.11	$4.02	$3.06	$3.05	$3.32	$1.42	$1.97	$2.84	$3.36	$4.24	$2.90	$3.36	$3.09

*Began reporting Semi-annually with 1984.

**The Monitor Program has recently experienced some changes in funding and operation: these data are preliminary and unofficial at this time.

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TABLE 2

Type of Drug Involved in Detroit Court Cases

(Source. City of Detroit Police Narcotics Unit)

Drug Type	1980 Number	1980 Percent	1981 Number	1981 Percent	1982 Number	1982 Percent	1983 Number	1983 Percent	1984 Number	1984 Percent	1985* Number	1985* Percent
Heroin	1291	55%	1356	54%	1565	57%	1310	57%	866	52%	496	42%
Methadone	11	<1	20	1	45	2	17	1	5	<1	3	<1
Marijuana (sale or distribution)	441	19	246	10	285	10	217	9	199	12	137	12
Amphetamines	33	1	36	1	56	2	71	3	18	1	9	1
Barbiturates	29	1	39	2	35	1	18	1	5	<1	3	<1
Cocaine	152	6	89	4	149	5	179	8	225	14	343	29
Codeine	19	1	47	2	97	4	173	7	159	10	131	11
Talwin			499	20	245	9	52	2	13	1	2	<1
Dilaudid	8	<1	7	<1	21	1	33	1	32	2	14	1
LSD	34	1	15	1	19	1	25	1	9	1	7	1
Morphine	1	<1	0	-	0	-	0	-	0	-	0	-
PCP	33	1	17	1	16	1	15	1	16	1	7	1
Quaalude	0	-	0	-	0	-	0	-	0	-	0	-
Valium	122	5	62	2	81	3	34	1	16	1	13	1
Other Drugs	69	3	24	1	78	3	137	6	66	4	18	2
Other Charges (drug involved)	98		46		35		31		24		0	
Total	2341	95%	2503	98%	2727	99%	2312	99%	1653	98%	1183	100%

*Through September 1985.

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TABLE 3

Narcotic Addiction Deaths

(Source: Wayne County Medical Examiner's Office: Dr. Montforte, 1985)

	Year											
Quarter	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985*
1st Quarter	56	79	51	23	28	20	34	26	31	40	40	53
2nd Quarter	55	79	55	23	13	20	36	27	63	21	40	66
3rd Quarter	46	124	57	29	20	20	54	38	48	39	34	50
4th Quarter	65	59	43	20	12	27	34	50	50	36	55	22*
Total	222	341	206	95	73	87	158	141	192	136	169	191*

*Through October 1985.

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12/85

TABLE 4

Drug Abuse Mentions - Reporting Emergency Rooms

Imputed Data

Detroit/Wayne County Area

July, 1982 - June, 1985

Source: DAWN (NIDA)

	1982		1983				1984				1985	
Drug Mentioned	Jul Sep	Oct Dec	Jan Mar	Apr Jun	Jul Sep	Oct Dec	Jan Mar	Apr Jun	Jul Sep	Oct Dec	Jan Mar	Apr Jun
Heroin	700	659	877	819	892	704	719	604	663	541	576	825
Marijuana	86	117	228	256	223	55	94	54	43	55	57	82
Cocaine	66	77	82	135	149	120	171	142	130	147	184	237
Dilaudid	35	28	24	41	39	29	31	31	14	11	8	11
PCP	28	26	32	40	22	22	29	22	18	25	15	7
Demerol	23	26	28	30	17	12	18	14	10	3	10	3
Codeine	10	9	14	16	14	20	27	15	12	12	14	9
Valium	199	193	172	144	111	132	160	117	103	112	101	86
Talwin	79	70	59	44	29	18	14	7	9	5	5	2
Alcohol-In-Combination	365	347	333	332	311	285	312	245	217	231	232	217
Total Mentions	2901	2774	3240	3168	3135	2625	3116	2608	2635	2556	2561	2709

Top five drugs mentioned, their ranking, and percentage of the total.

1982 (last six months)

1.	Heroin	24%
2.	Alcohol-In-Combination	13%
3.	Valium	7%
4.	Marijuana	4%
5.	Talwin	3%

1983

1.	Heroin	27%
2.	Alcohol-In-Combination	10%
3.	Marijuana	5%
4.	Valium	5%
5.	Cocaine	4%

1984

1.	Heroin	23%
2.	Alcohol-In-Combination	9%
3.	Cocaine	5%
4.	Valium	5%
5.	Marijuana	2%

1985 (first six months)

1.	Heroin	27%
2.	Alcohol-In-Combination	9%
3.	Cocaine	8%
4.	Valium	4%
5.	Marijuana	3%

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TABLE 5

Treatment Admissions by Primary Drug

(Source: Office of Substance Abuse Services)

Detroit/Wayne County

Primary Drug	FY 1980/81 Number of Admissions	FY 1980/81 Percent of Admissions	FY 1981/82 Number of Admissions	FY 1981/82 Percent of Admissions	FY 1982/83 Number of Admissions	FY 1982/83 Percent of Admissions	FY 1983/84 Number of Admissions	FY 1983/84 Percent of Admissions	FY 1984/85 Number of Admissions	FY 1984/85 Percent of Admissions
None	77	<1%	93	1%	113	1%	108	1%	97	<1%
Alcohol	7875	47	8571	53	10548	61	11114	60	10534	61
Amphetamines	227	1	158	1	105	1	114	1	80	1
Barbiturates	261	2	152	1	60	<1	47	<1	23	<1
Cocaine	181	1	124	1	187	1	473	3	1263	5
Hallucinogens	141	1	115	1	42	<1	53	<1	36	<1
Heroin	4917	30	4417	27	4115	24	4221	23	3410	20
Inhalants	15	<1	12	<1	12	<1	10	<1	3	<1
Marijuana/Hashish	1229	7	1065	7	820	5	761	4	647	4
Methadone (Non-Rx)	62	<1	41	<1	65	<1	83	<1	59	<1
Other Sedatives/ Hypnotics	79	<1	56	<1	24	<1	13	<1	8	<1
Other Opiates/ Synthetics	505	3	390	2	438	3	610	3	478	3
Over-the-Counter	19	<1	25	<1	5	<1	9	<1	4	<1
Tranquilizers	270	2	285	2	128	1	108	1	77	<1
PCP	113	1	103	1	72	<1	62	<1	44	<1
Multi-Drug	43	<1	65	<1	64	<1	93	1	96	1
Significant Other (Family)	173	1	264	2	402	2	431	2	774	4
Other	68	<1	53	<1	39	<1	25	<1	22	<1
Unknown	265	2	70	<1	15	<1	15	<1	8	<1
Not Reported	80	<1	154	1	38	<1	31	<1	28	<1
Total	16600	97%	16213	98%	17292	97%	18381	98%	17691	98%

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TABLE 6

Admissions by Primary Drug Type

Statewide vs. Detroit/Wayne County

(Source: Office of Substance Abuse Services)

Primary Drug	FY 1982/83 Statewide Admissions Number	Percent	FY 1982/83 Detroit/Wayne Co. Admissions Number	Percent	Detroit/Wayne Co. as a Percent of State Totals
Alcohol	32246	69%	10548	61%	33%
Heroin	4943	11	4115	24	83
Other Opiates and Synthetics	1182	3	503	3	43
All Others (Various)	8520	18	2126	12	25
Total	46891	101%	17292	100%	37%

Primary Drug	FY 1983/84 Statewide Admissions Number	Percent	FY 1983/84 Detroit/Wayne Co. Admissions Number	Percent	Detroit/Wayne Co. as a Percent of State Totals
Alcohol	34660	74%	11114	60%	32%
Heroin	4996	11	4221	23	84
Other Opiates and Synthetics	1149	2	693	4	60
All Other (Various)	6035	13	2353	13	39
Total	46840	100%	18381	100%	39%

Primary Drug	FY 1984/85 Statewide Admissions Number	Percent	FY 1984/85 Detroit/Wayne Co. Admissions Number	Percent	Detroit/Wayne Co. as a Percent of State Totals
Alcohol	34725	69%	10534	60%	30%
Heroin	4070	8	3410	19	84
Other Opiates and Synthetics	955	2	478	3	50
All Others (Various)	10301	21	3269	18	32
Total	50051	100%	17691	100%	35%

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TABLE 7

Year of First Use - Heroin Admissions

Statewide

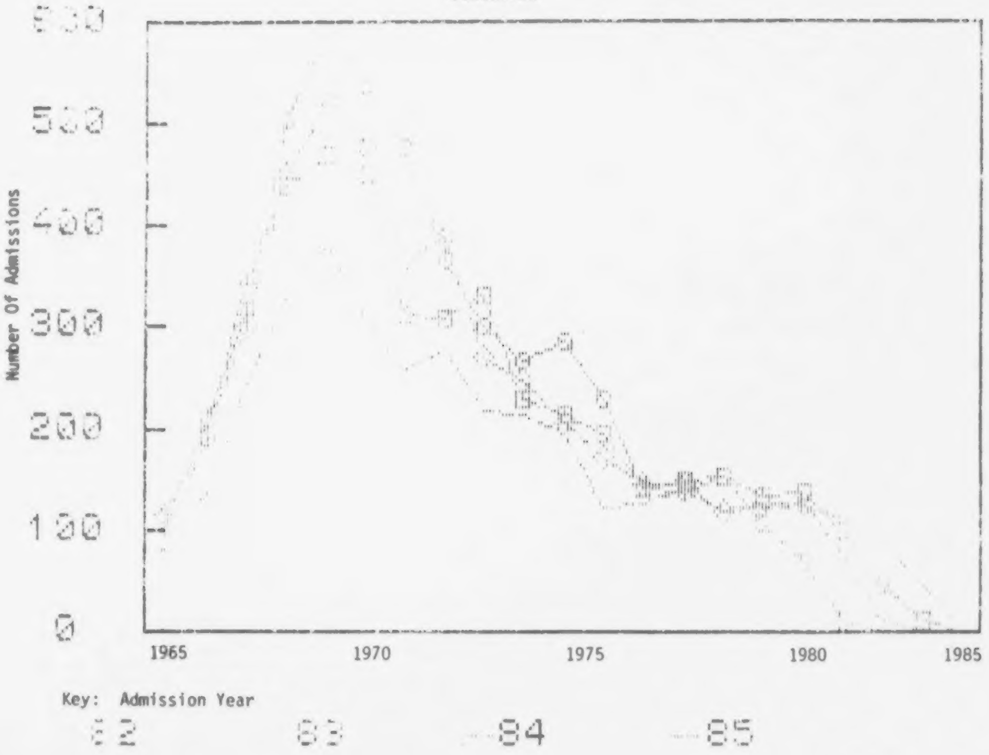

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TABLE 8

Year of First Use - Cocaine Admissions
Statewide

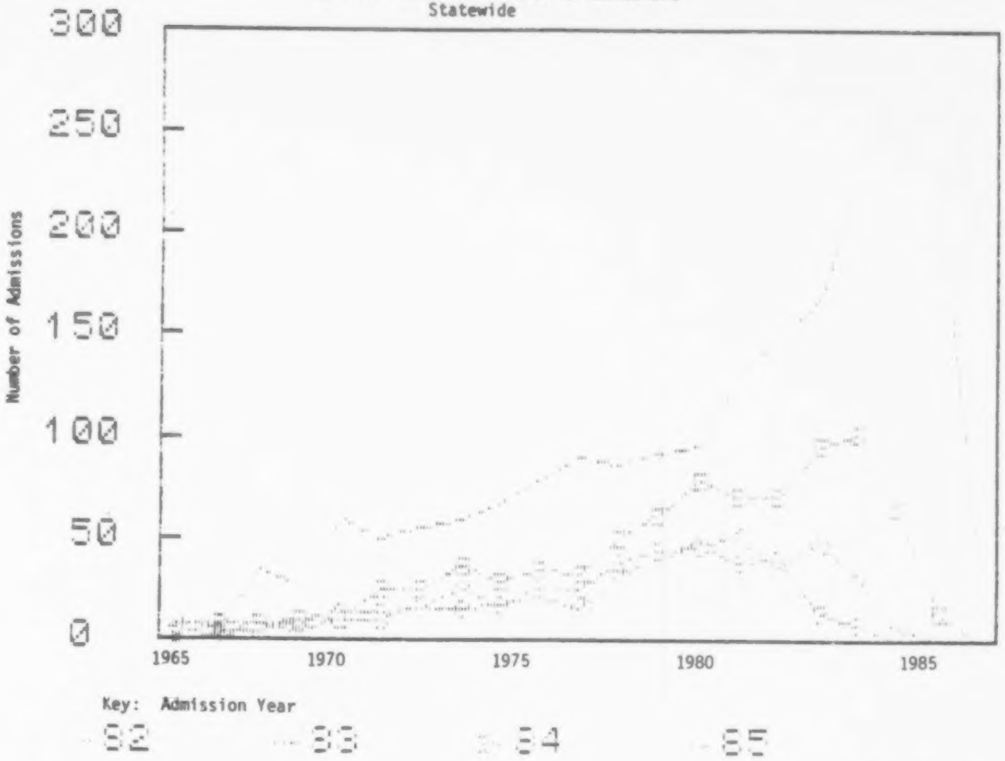

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TABLE 9

Year of First Use - Cocaine Admissions

Detroit/Wayne County

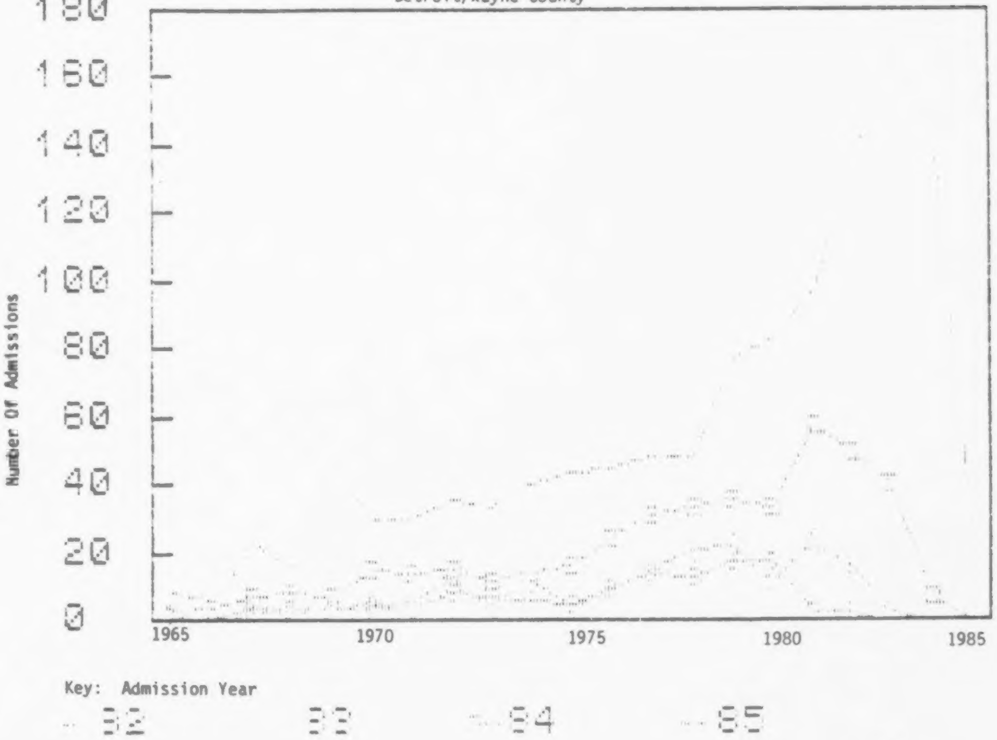

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TABLE 10

Opiate Admissions to Treatment

(Source: Office of Substance Abuse Services)

Detroit/Wayne County

	Year						
Quarter	1978/79	1979/80	1980/81	1981/82	1982/83	1983/84	1984/85
1st Quarter		1559	1339	1175	1331	1165	962
2nd Quarter	1244	1246	1455	1175	1110	1204	1025
3rd Quarter	1119	1573	1451	1161	1160	1247	987
4th Quarter	1484	1561	1239	1181	1183	1235	973
Total	3847	5939	5484	4692	4784	4851	3947

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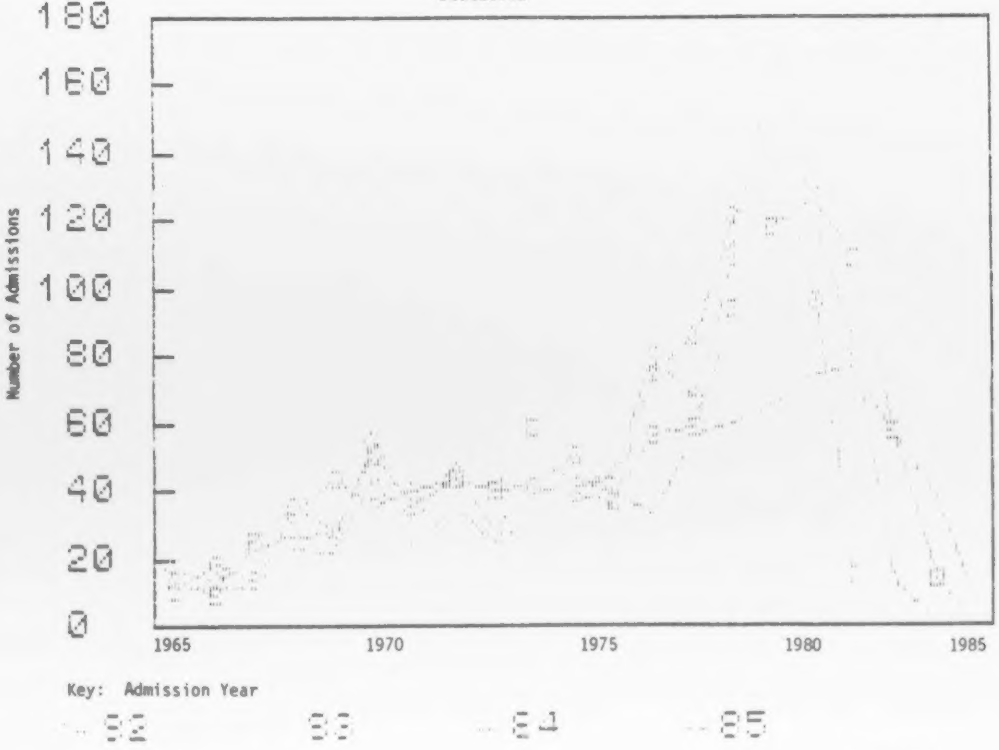
TABLE 11

Year of First Use - Other Opiates and Synthetics

Statewide



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12/85

DETROIT POLICE

CRIMINAL INVESTIGATION BUREAU

MAJOR CRIMES DIVISION

STATISTICAL REPORT

JANUARY, 1986

ARRESTS	JANUARY	1986	1985
By Narcotic Section			
State Law & US Drug Law	231		158
Other Crimes	0		0
Sub Total	231		158
By Other Section/Pct Processed by Narc Section & arrested by others including Traffic Ct & Marijuana Cases	227		149
TOTAL	458		307
Processed by Other Sections/ Precincts	90		69
GRAND TOTAL	548		376
2. DISPOSITIONS OF ARRESTS PROCESSED BY NARCOTIC SECTION TO COURT			
State Court	136		135
Traffic & Ordinance	22		10
SUB TOTAL	158		145
TOT Other Bureaus/Depts	81		18
Investigated and Discharged (including those discharged pending analysis	219		144
TOTAL	458		307
Processed by Other Sections/ Precincts	90		69
GRAND TOTAL	548		376
3. WARRANTS DENIED - NARCOTIC SECTION	5		17
4. BOARD OF HEALTH NOTIFICATIONS RE: ADDICTS			
NEW OPIATE ADDICTS (fr above)	DELETED PENDING REVIEW		
5. COMMUNICATIONS	53		72
6. DRUG STORE INSPECTIONS	0		0
7. PRESENTATIONS OF NARCOTIC DANGEROUS DRUGS			
Presentations	0		5
Attendance	0		260
Miles Traveled	0		35
Hours Traveled	0		11
8. NARCOTIC/DRUG COMPLAINTS			
Drug Activity Complaints Rpt	219		110
Drug Activity Cleared	38		15
Drug Activity Complaints Unfounded	8		12
Forged Prescriptions Complts Rpt	0		0
Forged Prescriptions Complt cleared	0		0
Forged Prescriptions Unfounded	0		0

	PERSONS ARRESTED IN 1986			TO STATE COURT		
MALES	January	1986	1985	January	1986	1985
Black	449		294	109		155
White	36		26	10		12
Mexican	2		1	2		1
FEMALES						
Black	52		44	14		18
White	9		10	1		9
Mexican	0		1	0		0
1986 GRAND TOTAL	548		376	136		195
1986 GRAND TOTAL				22		14
TO TRAFFIC COURT				158		209

10. COURT CASES IN 1986	CONVICTIONS			DISMISSALS		
Controlled Substance Act	68		49	7		9
CSA/CCW	0		0	0		0
Forged Scripts	0		0	0		0
Other Crimes	8		6	0		1
	76		55	7		10

*Dismissal include those cases the defendant went to trial and was found not quilty.

NOTE: DISPOSITION OF TRAFFIC COURT CASES (POSSESSION OF SMALL AMOUNT OF MARIJUANA LOITERING, AND POSSESSION OF NARCOTIC PARAPHERNALIA) ARE NOT FORWARDED TO THE NARCOTIC SECTION, THEREFORE, IT IS IMPOSSIBLE TO RECORD CONVICTIONS AND DISMISSALS OF TRAFFIC COURT CASES.

	SUMMARY OF COURT CASES		
	January	1986	1985
STATE COURT		136	135
TRAFFIC/ORDINANCE		22	10
GRAND TOTAL		158	146

SUMMARY OF STATE COURT DISPOSITIONS		
Prison	33	22
Probation	38	33
*Act 347 Probation w/adjudication	0	0
Fined	1	0
Suspended Sentence	4	0
GRAND TOTAL TO DATE 1985	76	55

*Act 347 - Effective April, 1972, includes all age groups. When applied, it is generally used in court cases where defendant had no prior record and/or convictions. It replace the formed, "Referred to Youth Training Act" catergory basically applied to youthful offenders only.

TYPE DRUG USED BY PERSONS ARRESTED BY AGE GROUP IN JANUARY, 1986

	-15	15-16	17-20	21-24	25-28	29-32	33-36	37-40	40+	January	1986	1985
HEROIN	0	2	19	16	9	10	7	3	9	75		93
METHADONE	0	0	0	0	0	0	1	0	0	1		0
MARIJUANA	1	5	15	14	8	1	10	3	10	67		49
AMPHETAMINES	0	0	0	0	0	0	0	1	0	1		0
BARBITURATES	0	0	0	0	0	0	0	0	0	0		0
COCAINE	3	2	16	20	15	6	7	8	5	82		43
LSD	0	0	0	1	0	0	0	0	0	1		1
DILAUDID	0	0	0	0	0	0	0	0	0	0		0
CODEINE	0	0	0	0	1	1	2	7	2	13		21
PCP	0	0	0	0	0	1	0	0	0	1		2
QUAALUDE	0	0	0	0	0	0	0	0	0	0		0
VALIUM	0	0	0	0	1	1	1	0	0	3		3
TALWIN	0	0	0	0	0	0	1	0	0	1		0
OTHERS	0	1	1	2	2	3	1	1	3	14		11
NON USERS OR UNK IF PERSON ARRESTED ACTUALLY DRUG USER*												
TOTALS	0	8	46	46	31	48	45	30	35	289		153
	4	18	97	99	67	71	75	53	64	548		376

*UNK CATEGORY - ARRESTED SUBJECTS WHO REFUSE TO EITHER CONFIRM OR DENY USE OF ANY TYPE DRUGS AND WHO BEAR NO VISUAL SIGNS (NEEDLE MARKS) NOR PHYSICAL SYMPTOMS (WITHDRAWAL) TO INDICATE USE

PERSONS ARRESTED (BY RACE, SEX, AND AGE) IN

MALES												
Black	4	16	91	82	46	56	52	45	57	449		294
White	0	1	4	5	8	7	5	0	6	36		26
Mexican	0	0	0	0	0	0	2	0	0	2		1
Other	0	0	0	0	0	0	0	0	0	0		0
FEMALES												
Black	0	1	2	8	12	6	14	8	1	52		44
White	0	0	0	4	1	2	2	0	0	9		10
Mexican	0	0	0	0	0	0	0	0	0	0		1
Other	0	0	0	0	0	0	0	0	0	0		0
TOTAL 1986 TOTALS	4	18	97	99	67	71	75	53	64	548		376

NOTE: TOTALS DO NOT INCLUDE THOSE CHARGED IN TRAFFIC COURT WITH MINOR AMOUNTS OF MARIJUANA, LOITERING, OR POSSESSION OF NARCOTIC PARAPHERNALIA

	JANUARY 1986	1985
HEROIN	45	62
METHADONE	1	0
MARIJUANA	20	18
AMPHETAMINES	1	0
BARBITURATES	0	0
COCAINE	49	27
CODEINE	8	20
TALWIN	1	0
DILAUDID	0	0
LSD	1	1
MESCALINE	0	0
MORPHINE	0	0
PCP	1	3
QUAALUDE	0	0
VALIUM	3	2
OTHERS	6	2
FRAUD PROCUREMENT	0	0
COURT INVOLVED NO-DRUG	0	0
DRUG CCW	0	0
TOTALS 1984	136	135

TYPE DRUG CONFISCATED	January, 1986	1986	1985
HEROIN	350.0 grs		1 lb. + 2.40 grs.
METHADONE	0		4 tabs
MARIJUANA	84 lbs		192 lbs
COCAINE	3 lbs. + 440.2 grs		325.0 grs
MORPHINE	0		0
OPIUM	0		0
NO CASE EVIDENCE			
SUSPECTED HEROIN/COCAINE	7 lbs. + 180.8 grs		2 lbs. + 201.8 grs
SUSPECTED MARIJUANA	6 lbs.		10 lbs
SUSPECTED DANGEROUS DRUGS	3526 tabs		3,895 tabs
DANGEROUS DRUGS			
AMPHETAMINES	174 tabs		578 tabs
BARBITURATES	0		0
CODEINE	759 tabs		0
PCP	6.49 grs		19.83 grs
OXOCODINE (Percodan)	28 tabs		0
PCE	0		0
PROPOXPHINE	0		0
TALWINS	0		0
DEMORAL	0		350 tabs
DILAUDID	0		220 tabs
LSD	46 tabs		6,059 tabs
QUAALUDE	0		0
VALIUM	89 tabs		128 tabs
OTHERS	0		0
	1,096 tabs + 6.49 grs		7,335 tabs + 19.83 grs

OTHER TYPE CONFISCATIONS	JANUARY, 1986	1986	1985
Forged Prescriptions	0		0
Guns	149		104
Hypodermic	0		24
Motor Vehicle Seized	6		1
Narcotic Section Lock Seal Folders (No Case Substance) Not analyzed No Prosecution	163		96
Narcotic Proceeds	$96,368.00		$57,665.00
Secret Service Funds	$9,185.00		$951.00

Joel Gilliam
JOEL GILLIAM
Inspector
Commanding Officer
Narcotic Section

/as

- The average beginning age for alcohol use in America is 12 2 years - 13 years for marijuana. Youth today face decisions about drugs that no previous generation has had to make.

- The U.S. Surgeon General estimate that 1/3 of the young people under 18 are involved regularly with some form of illicit drugs.

- In the 16-19 age group, 14 people are killed and 129 injured DAILY in alcohol related automobile accidents.

- The suicide rate for teens (12-18) has more than tripled in the last 20 years.

- NIDA reports that nationally 100,000 youths (ages 14-15) and 260,000 (ages 16-17) use cocaine. 5,000 persons in the U.S. each day try cocaine for the first time.

- **While the use of many illicit drugs is declining from peak levels attained in the 70's, substance abuse in America is the highest of any developed country in the world.**

WE ARE . . . .

Michigan Communities in Action for Drug-Free Youth, founded in March 1984, is a non-profit grassroots organization. MCA encourages parent/community/youth groups, concerned citizens, and professionals working together to prevent and reduce the use of illegal alcohol and other drugs by our youth

WE BELIEVE

that strong, knowledgeable, caring families working in concert with schools, service and civic groups, religious groups, media, law enforcement and medical and drug-related agencies is the best way to help our youth choose drug-free alternatives in their lives.

WE DO . . .

provide a state network and resource center through which there is a sharing of concerns, ideas, success stories, and current, credible educational and factual research information, newsletters, toll-free telephone and annual state conferences.

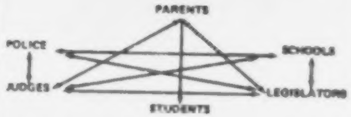
- Assist in the formation of new parent/community/youth groups.
- Establish a link with other state networks and national umbrella parent movement organizations in Michigan.
- Continue the expansion of our network and resource center.
- Encourage communities to call on law enforcement, juvenile justice agencies, and local government to establish plans of action regarding sales of drug paraphernalia, liquor sales to minors, teenage drinking, and other drug related issues.
- Host a youth conference in addition to the annual parent-professional conference.
- Influence pertinent legislation.

Prevention must begin with public awareness of the problem, an understanding of what can be done to improve the situation and a willingness to do something about it.

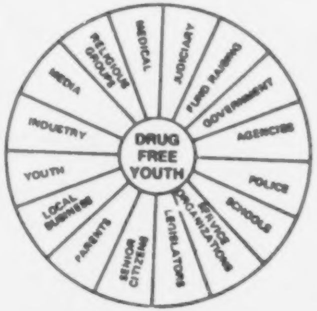
What is the Problem?

Adolescents' use of alcohol and other drugs and recognizing this serious threat to their health and well being.

Who Takes Responsibility?



We are all involved and we are all affected. We must be positive and non-blaming.



What Part of the Solution are You ?

Michigan Communities in Action for Drug-Free Youth

PREVENTION THROUGH EDUCATION AND AND COMMUNITY ACTION....

MCA is dedicated to promoting and encouraging the parent movement philosophy as we show a loving concern for Michigan's most valuable resource-our sons and daughters.

WHAT COMMUNITIES CAN DO . . .

Organize Parent/Community/Youth Groups

A parent/community/youth groups is any number of concerned citizens coming together with a goal of influencing their children, schools and community toward drug-free youth

- Educate themselves, their families and the community on the signs and dangers of the use of alcohol and other drugs.
- Work together with local schools to develop a united effort among the administrators, teachers/counselors, parents and students.
- Encourage interaction with other community resource segments which support drug-free ideals for youth
- Reach out and help youth interested in peer counseling, drug-free parties and community activities.

PARENTS CAN....
- Be informed
- Be available
- Be loving
- Be role models
- Be consistent

Michigan Communities
in Action for
Drug-Free Youth
470 North Woodward Avenue
Birmingham, MI 48011
(313) 642-6270
1-800-622-6849

Help MCA to help our young people through caring, contributing and uniting together. Please support this effort with your tax-deductible donation.

☐ DONATION ☐ ORGANIZATION $25 ☐ FAMILY $10 ☐ STUDENT $5

NAME ______________________ TELEPHONE (   ) __________

ORGANIZATION ______________________

ADDRESS ______________________
STREET CITY STATE ZIP

MAKE CHECK PAYABLE TO:

MICHIGAN COMMUNITIES IN ACTION FOR DRUG-FREE YOUTH
470 North Woodward Avenue
Birmingham, MI 48011

FACT SHEET

PRESS RELEASE CONCENRNING "CRACK" COCAINE BY ROY C. HAYES, U.S. ATTORNEY, EASTERN DISTRICT OF MICHIGAN AND ROBERT J. DEFAUW, SPECIAL AGENT IN CHARGE, DRUG ENFORCEMENT ADMINISTRATION, DETROIT FIELD DIVISION

"Crack" is cocaine freebase. Cocaine hydrochloride in which the cocaine base or alkaloid has been freed from the hydrochloride ions or salt.

"Crack" is commonly sold in small quantities. It first appeared in Los Angeles and Miami in 1984 and more recently in New York and New Jersey as well as Detroit and other major cities.

"Crack" is described as a white coagulated powder resembling slivers of soap in appearance and is manufactured by converting cocaine hydrochloride back to base using baking soda and water instead of volatile chemicals previously used in the freebasing process.

"Crack" is sold in pellets usually two or three to a vial. One "pea" size pellet, an average dose, weighs 125 mg and sells for about $20.00. The pellets are either smoked in a pipe or crumbled into tobacco or marijuana cigarettes.

Mid-level dealers obtain cocaine hydrochloride, process it into cocaine freebase in home style laboratories, and distribute the finished product themselves. Some laboratories also provide rooms where "crack" can be smoked. These establishments are known as "crack houses".

"Crack" is available in different size pellets ranging in price from $10 to $100.00. The purity ranges at approximately 92%.

In Miami last year, Metro Dade Police raided over 120 freebase houses. In each police raid, the operators of the freebasing houses were armed. Freebase house operators generally fence stolen property, jewelry, household appliances, and televisions. Those items are generally accepted as payment for "crack".

"Crack" is a user level drug distributed by street groups and usually found in small quantities. Cocaine smoking is really the story behind "crack". Inhaling (the only way to ingest cocaine freebase) has a higher abuse liability than snorting or injecting cocaine hydrochloride.

Smoking completely bypasses the venous system bringing the drug directly to the brain within seconds after inhaling. Smoking cocaine freebase is gaining in popularity.

Of 18 cities represented at NIDA'S recent conference on drug trends in the United States, 14 reported that smoking cocaine freebase is on the increase and 14 also reported that "crack" is available in their cities.

Obtaining a country wide perspective on "crack" is impossible because street names in packaging differs from city to city. Prepared cocaine freebase under a variety of names has been around for a while but pinning down when and where is largely a matter of street intelligence.

The Drug Enforcement Administration, Drug Abuse Warning Network, (DAWN) tracks smoking as a means of administration but doesn't differentiate between crack and cocaine freebase that has been processed by the user. Nomenclative differences add to the confusion i.e. freebase "rocks" are the same as "crack" but "rock" cocaine is something entirely different. "Rock" cocaine is cocaine hydrochloride that has been compressed and stamped like a pill. "Rock Houses" raided in the Los Angeles area were producing rock cocaine which purchasers would pulverize and snort. Smoking of cocaine has a potential for growth given the availability of inexpensive ready to smoke and high potent cocaine products such as "crack".

The risk to the user of becoming addicted to cocaine is ranked most closely with how the user administers the drug or how it is consumed. Smoking high potency cocaine carries the greatest risk.

DEA anticipates that cocaine suppliers will take advantage of the increased demand for cocaine based products particularly since the development of high potency products eliminates difficulties previously posed by restricted access to chemicals essential to the normal production of cocaine hydrocholoride. Another coca derivative commonly referred to as "basuco", also known as cocaine sulfate, paste, or base, refers to a preliminary coca product during the conversion process to cocaine HCl. "Basuco" can be smoked directly usually mixed the same as "crack" with tobacco and marijuana and smoked in a cigarette. It is the most inexpensive form of cocaine but it contains the most contaminants. Basuco, once confined to South America, is now being used to a very limited degree in the Miami area and is of low purity.

Wayne County statistics on deaths attributed to narcotics overdoses, January, 1985 to November, 1985. 199 cases were attributed to narcotics overdoses mostly poly-drug abuse. 23 of those cases showed indications of death attributed to cocaine or cocaine poly-drug abuse. In the previous year the number of deaths identified as being caused by use of cocaine or poly-drug abuse was between six and ten.

Generally speaking, nationwide the rise in cocaine related injuries and deaths resulted from the increased use of cocaine in combination with other drugs, coupled with the previously described more diverse forms of use such as freebasing and injection. The number of hospital emergencies resulting from intravenous use of cocaine and heroin rose 37 percent. 59% of those who died from cocaine related causes were taking more than one drug. It should be noted that emergency room admissions resulting from the use of cocaine in conjunction with alcohol, heroin, and PCP have been increasing since 1982.

According to the National 800-Cocaine Help Line, calls eminating from the Detroit area concerning "crack" abuse has placed Detroit among the top five major cities in the United States for this type of abuse. As a result, DEA Detroit along with state and local authorities are intensifing their efforts to combat this problem.

Cocaine, commonly referred to as "The Lady" in street terms or jargon, can be lethal. SAC DeFauw states "The Lady" is really a seductress. She will ruin a family. She will ruin friends and she will kill the user." When Len Bias and Dan Rogers died last week, the sports world was stunned, but death by drugs has become common in all facets of society.

Nationally and locally, the list of people who have died from drugs grows.....the time has come for society to unite and say no to drugs and assist law enforcement in stopping the drug trafficking menace.

DEA, working in close conjunction with state and local law enforcement, has established a 313-NO CRACK telephone number to curtail the cocaine traffic in Michigan. Help law enforcement help you.

All telephone calls will be handled by law enforcement personnel. Confidentiality will be protected. All information will be analysed and investigated. Rewards will be paid for information leading to substantive arrests, seizures, and prosecutions. Call 313-NO CRACK and save a family, a friend, and maybe even you.

Years ago men and women joined forces and fought against intruders for freedom in this country and they won. Help law enforcement free this area of the number one enemy COCAINE. Together we can win the war on drugs, call 313-NO CRACK.

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February 1985

Probing the Links Between Drugs and Crime

Bernard A. Gropper, Ph.D.

The nature and extent of the linkages between drugs and crime are far from being fully understood. Yet, the belief that they *are* linked is fundamental to our efforts to control crime through the prevention and control of drug abuse.

Considerable evidence has been accumulated over the years that drugs and crime are often found together, and many theories have been advanced attempting to explain how many factors—including drugs—may contribute to the onset or continuance of criminal behavior (BJS, March 1983; Gandossy et al., 1980). A recent national survey, for example, reported that almost one-third of all inmates of State prisons were under the influence of an illegal drug or had drunk very heavily just before they committed the crimes for which they were incarcerated (BJS, Jan. 1983; BJS, March 1983).

Such aggregate data strongly suggest, but cannot directly assess, the degree to which the presence of these substances contributed to the occurrence of these crimes or to their severity because they fail to link individual drug consumption to individual crime commission.

To be a useful guide for public policy, research on the links between drugs and crime must be tailored to specific policy areas. Aggregate statistics, for example, can tell us something about overall numbers of drug abusers, total costs of drugs to society, or other large-scale questions, but they offer little insight into many other issues important to policymakers. Informed public policy also requires knowledge of individual and small-group questions—the "hows" and "whys" by which drug abuse and crime are linked at the user level.

This article briefly summarizes some findings from recent research that examined the nature and extent of drug-crime links at the individual offender level. The studies reviewed assess some of the fundamental assumptions un-

From the Director

The National Institute of Justice has made research on the relationship of drugs to crime a priority. In this Brief, Institute staff member Bernard A. Gropper reviews key findings from current research in this important area.

I am pleased that Dr. Gropper has pulled together highlights not only from the studies he has been managing for the Institute but from research sponsored by other agencies that make up our Nation's combined efforts against drug abuse.

The evidence emerging from the research is helping to advance our understanding of the "hows" and "whys" of drug-crime linkages. It indicates that intensive narcotics abusers are heavily involved in crime, much of it violent. Contrary to what has been believed, heroin-using criminals appear to be just as likely as non-drug-using offenders to commit violent crimes such as homicide and rape and even more likely to commit robberies and weapons offenses.

Such research has important policy implications. It dispels the myth that the only victims of drug abuse are the consumers. It reveals that many addicts are more violent than was previously believed. And it tells us that targeting enforcement and treatment efforts against the serious, heavy narcotics abuser is likely to give us the greatest payoff in terms of crime reduction.

The new knowledge emerging from research is important to all those concerned about drug abuse—not just criminal justice officials but parent groups and school officials. Increasingly, they can turn to objective data to inform the debate over drugs. Such information can form the basis for more effective prevention and control policies, thus reducing the possibility that innocent victims may pay the price of uninformed policies.

James K. Stewart
Director
National Institute of Justice

derlying drug control and treatment policies. Among these are:

- Different levels of abuse of such drugs as heroin are directly related to criminality at the individual level, and individuals who abuse such drugs in differing degrees of severity will tend to have corresponding patterns of severity in criminal behavior.

- Even among high-risk individuals with established patterns of both drug abuse and criminality, an increase or reduction in level of drug abuse will be associated with a corresponding increase or reduction in criminality.

- Street-level heroin abusers tend to engage in a variety of criminal acts and other behavior to support their drug habits and personal survival needs, with corresponding costs to their victims, their families, and society in general.

Effects of drugs on criminality

Drugs and violent crime. Recently completed National Institute of Justice-supported studies of career criminals by researchers at RAND (Chaiken and Chaiken, 1982) found that a majority of the most serious offenders (the "violent predators") among the inmates in prisons and jails of three States had histories of heroin use, frequently in combination with alcohol and other drugs. Such a history of drug abuse, in fact, proved to be one of the best "predictors" of serious career criminality.

Other National Institute of Justice-funded research (Wish, 1982; Johnson, Wish, Strug, and Chaiken, 1983) indicates that narcotics abusers engage in violence more often than earlier studies would lead us to believe. Recent studies have shown that heroin-using offenders are just *as likely* as their non-drug-using or non-heroin-using counterparts to commit violent crimes (such as homicide, sexual assault, and arson), and even *more likely* to commit robbery and weapons offenses.

Data being developed by researchers at the Interdisciplinary Research Center on the Relations of Drugs and Alcohol to Crime (IRC) lend further support to the growing body of evidence suggesting that drug abusers are at high risk for violence. Reports from several cities indicate that one-quarter or more of homicides are related to drug-trafficking (Goldstein, 1982; McBride, 1983).

Perhaps even more disturbing is the finding that 75 percent of all robberies reported by a national sample of youth and 50 percent of the felony assaults were due to a small, but highly criminal, group. This was the subsample, comprising less than 3 percent of all youth, who had committed three or more index offenses *and* were pill or cocaine/heroin users (Johnson, Wish, and Huizinga, 1983).

The role of research in separating myth from reality

Drugs are surrounded by myth and, to some extent, probably always will be. But closer examination and systematic research have shown that many widely held beliefs about drugs and drug users are untrue, and that others are relatively simplistic. The reality of drug abuse is so interconnected with other factors affecting human behavior as to make such beliefs a poor basis for guiding public policy unless those other factors are also taken into account.

Direct and indirect relations between drugs and crime. National policy concerns and National Institute of Justice's overall research objectives encompass both the *direct* and *indirect* relations of substance abuse to criminal behavior—the ways in which drug abuse and trafficking affect the behaviors and crime patterns of those *directly* involved (whether they use the drugs themselves or simply deal in them), and the *indirect impacts* of drug abuse and drug-related crime on our criminal justice system and all levels of our society.

The *direct impacts* of drugs or alcohol on a user's behavior reflect both physical and physiological factors. The near-term effects are influenced not only by the *types* and *quantity* of drugs consumed, but also by such other *individual* and *situational* variables as the user's prior exposure (level of tolerance for the specific drug or its close pharmacological relatives), route of administration (swallowed, inhaled, injected), and psychological state (personality traits, expectations, social setting, etc.).

The *immediate outcomes* may vary from the user's passing out, experiencing pleasant to violent mood changes, or suffering perceptual distortions and decreased psychomotor control capabilities. These, in turn, can lead to further behavioral changes such as aggression, decreased abilities to judge time and distance, and loss of skill and control while driving—with *consequences* that can vary from minor embarrassments to loss of the lives and property of the drug abusers themselves or those around them.

Longer term effects, addiction, and causal mechanisms. Beyond considering the types of immediate impacts of mood-altering drugs and the short-term mechanisms by which they act on user behaviors, we must also recognize the longer term effects that tend to come with their continued use and abuse. Repeated and intensified use typically lead to a degree of *psychological or physical dependence* (addiction) that is destructive and costly to the user and to society.

The psychopharmacological and behavioral sciences have not established *any* drugs (or combination of drugs) as inherently or directly *"criminogenic"* in the simple sense that they compel users to commit crime. But, the overall cumulative evidence is clear and persuasive that the consistently demonstrated patterns of correlation between drug abuse and crime reflect real, albeit *indirect, causal* links.

Knowledge as the base of informed public policies. Unfortunately, recurrent and persistent myths appear to play a large part in sustaining the appeal of drug abuse for the uninformed. Over the years, similar claims have been made for many drugs as being nonaddictive (e.g., heroin and cocaine), "mind expanders," "sex enhancers," "benign" forms of recreation, and so on. The reality has proven to be less attractive. An important role of policy-oriented research is to separate such myth from reality and to continually develop and update knowledge on which informed policies aimed at the prevention and control of drug abuse and drug-related crime can be based.

Robberies and assaults, in fact, are proving to be rare among criminally active youths who are *not* also involved in illicit drug use. While such data cannot show whether drug abuse is necessarily the primary or only cause of these behaviors, they do show that it is very much a characteristic of serious and violent offenders.

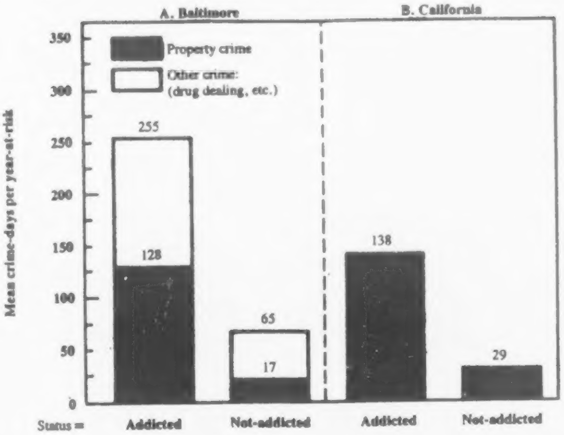
Changes in crime with changes in drug use. Among the most compelling evidence of the impacts of hard drug use on crime are the findings reported by teams of researchers in Baltimore (Ball, Shaffer, and Nurco, 1983) and at UCLA (McGlothlin et al., 1978; Anglin and Speckart, 1984). These studies clearly confirm one of the major assumptions of drug treatment—that reducing the level of drug usage can reduce the level of criminal activity, even among relatively hard-core drug users.

The Baltimore team analyzed background factors and long-term patterns of crime for 354 black and white male heroin addicts. The sample was drawn from more than 7,500 known opiate users arrested (or identified) by Baltimore police between 1952 and 1976 so as to be representative of the addict male population at large.

The results show how the intensity of the criminal behavior—especially property crime—of such addicts tends to be directly related to their current drug use status. During a 9-year period at risk, their crime rates dropped to relatively low levels during periods when they had little or no narcotic use. While they were actively addicted, however, their criminality was typically about 4 times to 6 times higher (Figure 1). Overall, they averaged 2,000 crime-days (defined as any day on which they committed one or more crimes) per addict. For those who had several periods of addiction and reduction or cessation of narcotics use, the levels of criminality clearly tended to rise and fall with drug usage.

The UCLA team's analyses yield parallel patterns. Their Southern California sample consisted of 753 white and Hispanic heroin addicts admitted to methadone maintenance programs from 1971 to 1978 (see Table 1 for a subsample of this group). Contrasting these addicts' criminal involvements in the year prior to their first addiction

Figure 1. Changes in criminality by narcotic addiction status



Sources: A.) Ball, Shaffer & Nurco, 1983 B.) Anglin & Speckart, 1984

Table 1. Relations of narcotic usage level to criminal behaviors and arrest rates

Ethnic subgroup: Subsample size[1]	**White** (N = 68)		**Hispanic** (N = 92)	
Usage level:	**Daily**	**Less than daily**	**Daily**	**Less than daily**
Criminal Behaviors: (per nonincarcerated person-year)				
a) Percent of time at this usage level:	53%	47%	55%	45%
b) Crime-days:				
Overall total:	138	29	129	20
Theft	77	24	81	12
Burglary	49	3	47	6
Robbery	3	0	2	0
Forgery	8	1	2	0
Other	1	3	8	4
c) Arrest rates:				
Overall total:	2.37	1.04	2.35	1.12
Drug possession	.77	.23	87	.28
Burglary grand theft	.42	14	.35	.12
Petty theft	.19	.08	.17	.06
Drug sales	.10	.02	.07	.03
Robbery	.09	.03	.04	.02
Forgery	.06	.01	.02	.00
Violence	.05	.03	.07	.05
Minor & other	.39	.30	.50	.37
d) Crime dollars	14,900	1,500	10,700	1,000

Source: Anglin and Speckart, 1984.

[1] Subsamples who reported being addicted between 25 and 75 percent of the time during their addiction careers.

(defined as the first period of daily heroin use for 1 month or more) with their criminality in the year after revealed notable increases.

Arrest rates increased from 40 to 100 percent overall, with the largest increases occurring for burglary and theft. There were 21 to 30 percent increases in the numbers of individuals engaging in crime from the pre- to post-addiction years, and three- to five-fold increases in the numbers of days on which they committed crimes. For example, white males reported 20 crime-days per nonincarcerated year in the 12 months prior to first addiction and 92 in the year after; Hispanic males reported 36 and 107 crime-days, respectively.

Costs of street level addiction and crime

Another recent study, under National Institute of Justice and National Institute on Drug Abuse cosponsorship, explored the behaviors and economic impacts of street-level opiate abusers (Johnson et al., 1985). Its findings indicate that, although these abusers are able to obtain drugs and survive through many methods, criminality is very common among them and clearly related to their levels and patterns of drug usage.

The research team, from the IRC at the New York State Division of Substance Abuse Services, gathered data from 201 heroin users who were recruited directly from their Central and East Harlem neighborhoods. The subjects provided 11,417 person-days of self-reported data during 1980 to 1982 on their day-to-day drug usage and how they supported themselves.

The study classified users according to their frequency of drug use: *daily* (6 to 7 days per week), *regular* (3 to 5 days per week), or *irregular* (2 days or less per week). The findings provide a far more detailed picture of the street-level economics of drug usage and crime than has previously been available.

Patterns of drug use and crime. Like the Baltimore addicts, most of the Harlem heroin abusers committed a large number of nondrug crimes and an even larger number of drug distribution offenses. Daily heroin users reported the highest crime rates (Figure 2). They averaged 316 drug sales per year and participated in 564 more drug distribution offenses through "steering" (directing customers to sources of supply), "touting" (promoting a particular dealer's drugs) or "copping" (conveying drugs and money between buyers and sellers, who may not actually meet). Daily heroin users also committed more *violent crimes* (i.e., robberies), one-quarter or more of which were committed against other drug users or dealers, drunks, and other street people.

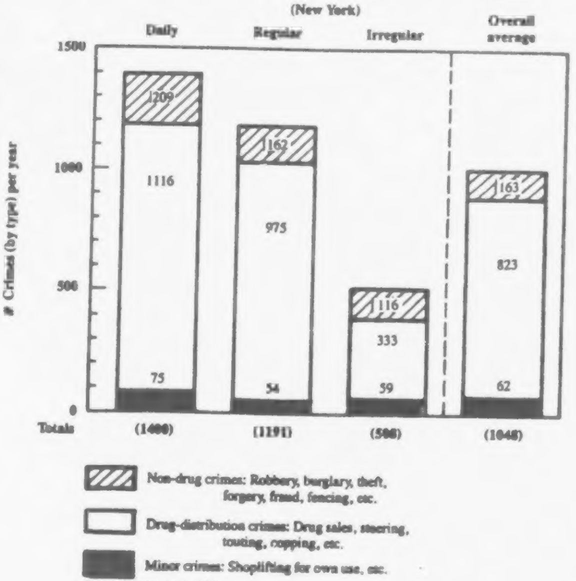
Almost all tended to use a variety of other drugs in addition to heroin; 90 percent also used cocaine and alcohol, and 73 percent used marijuana. Some drug use occurred on 85 percent of the days—heroin on 54 percent of the days, alcohol on 51 percent, cocaine on 27 percent, and illicit methadone on 10 percent.

The daily heroin users each consumed over $17,000 worth of drugs per year, compared to about $5,000 for the irregular users, with *noncash* arrangements covering about one-third of their consumption. Daily heroin users also committed about twice as many robberies and burglaries as regular users, and about five times as many as the irregular users.

However, the daily heroin users did *not* tend to commit more crimes per day than the other groups. Most of them had more criminal cash income during a year only because they were criminally active on *more days* (209 nondrug crimes per year compared with 162 among regular and 116 among irregular users). The daily users did *not* tend to have significantly higher arrest or incarceration rates than the less intensive users, and may thus be considered more "successful" as criminals since they committed more crimes and used more drugs than the less regular users.

Figure 2. Crime rates of street heroin abusers by level of drug usage

(New York)



Source: Johnson et. al., 1985.

Relatively modest returns per crime. The returns per-crime proved to be relatively small, though they tended to be somewhat greater for the daily users ($41 per crime) than the $25 per crime netted by the irregular users. The average returns from robbery ($80) and burglary ($81) were modest compared with the risks. The typical drug sale or distribution offense provided $5 or less cash income.

The average daily heroin user gained over $11,000 per year *cash* income from crime. This rose to over $18,000 total when the economic value of the drugs received without cash payment is included. In comparison, an irregular user netted only $6,000 total.

Economic impacts on victims and society. These figures do not represent the full range of economic consequences that heroin users impose upon other persons and upon society. To provide a somewhat more extensive picture, Johnson et al. (1985) developed estimates of 33 different types of economic harm imposed by such street heroin abusers. Among them were:

- *Nondrug crime*. The average street heroin abuser committed "nondrug" crimes (including burglary, robbery, and theft) from which victims suffered an economic loss of almost $14,000 annually, based on the retail value of stolen goods. The toll from such nondrug crimes by daily heroin users was nearly four times (almost $23,000) that of the irregular users (almost $6,000).
- *Freeloading*. The public and relatives or friends of daily heroin users contributed over $7,000 annually to them in the form of public transfer payments, evasion of taxes, cash "loans," and shelter and meals.
- *Drug distribution crimes*. Street heroin abusers contribute substantially to the "underground economy." In addition to being drug consumers, they function as low-level drug dealers and distributors. In this New York sample, the average daily heroin user distributed approximately $26,000 per year in illegal drugs. From this, they received about 40 percent in cash or drug "wages," while 60 percent went to higher level dealers and others in the illegal drug distribution system.

The combined costs imposed on society by the daily heroin users in this study totaled about $55,000 annually per offender. Regular heroin users cost society about $32,000, and irregular users about $15,000 each per year. These costs are *in addition* to those due to other economic factors typically addressed by prior research on social costs—such as foregone productivity of legitimate work; criminal justice system expenses for police, courts, corrections, probation and parole; treatment costs; private crime prevention costs; and less tangible costs due to fear of crime and the suffering of victims.

Policy implications

What sort of overall picture can we draw from the types of studies summarized here? And, when combined with data from other ongoing efforts at monitoring the current "drug scene," what are some of the implications for our policies to prevent and control drug abuse and drug-related crime?

Perhaps the foremost finding is that heroin abusers, especially daily users, commit an extraordinary amount of crime. These studies reveal a lifestyle that is enveloped in drug use and crime. The major impetus for most of their criminal behavior is the need to obtain heroin or opiates. A large majority reported that they were only sporadically employed, if employed at all, during their active addiction periods, that they were generally helped or supported by a relative or friend, and that they had little legally generated income of their own.

Other information on the changing street scene suggests that heroin and other drugs are now typically so "cut" or impure that true addiction is less likely than in the past. Together with the insights into how street-level users support their needs through cash and noncash means, these findings suggest the notion that addicts typically have uncontrollable cravings that compel them to commit crime immediately in order to get money to buy drugs is less valid for today's users.

Although narcotic addicts and users as a group engage in a great deal of crime, the amounts and types of crimes committed vary considerably among individuals. For the majority of users, their current patterns of criminality are strongly influenced by their current drug usage status. Based on the findings discussed here, treatment and education programs targeted toward reducing drug usage by the most *frequent* and *intensive* users could gain more significant reductions in drug-related criminality than undirected efforts or those aimed toward lesser users.

Information from other ongoing studies is also providing greater insight into the specific roles of drug and alcohol use in criminal events, both among heroin abusers and the general youth population. These confirm that street-level "addicts" can control their compulsion for drugs to some extent and can decrease or stop their drug usage for significant periods of time. In addition, both hard-core and less intensive users tend to modulate or defer their use until the social or criminal situation is more appropriate, typically taking few or no drugs before critical events—such as before committing a theft—and deferring intensive usage for safer situations or settings, such as after the crime is completed (Johnson, Wish, and Huizinga, 1983).

This article is a "progress report" on the continuing research efforts to develop current and indepth knowledge on how drugs affect crime. These findings are only part of a larger, broader series of interrelated efforts by both National Institute of Justice and other organizations to improve our understanding of the nature and extent of drug-crime linkages. Together, they help provide sound informational bases for the guidance of public policies directed toward the prevention and control of drug-related crime.

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STATEMENT OF

FATHER COLEMAN COSTELLO

EXECUTIVE DIRECTOR
OUTREACH PROJECT
REGO PARK, NEW YORK

JULY 15, 1986

BEFORE THE
SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES
AND
SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

JOINT HEARING

"THE CRACK COCAINE CRISIS"

Good day. I am happy to come before the joint Select Committees to testify on Crack and also on our model residential program as well as our Substance Abuse Ministry Training Program.

The Outreach Project was founded six years ago in January 1980 as a response to the ever growing number of individuals who were experiencing drug and alcohol problems. We currently service 3,500 individuals a year at our 6 Queens based locations. At these various locations are our clinical and administrative offices, our vocational component, residential treatment, court advocacy program and our family services alcohol clinic.

When we started operations back in 1980 PCP (angel dust) was one of the major presenting problem drugs being abused by our clients. Today, 1986, Cocaine has become the major presenting problem of 75% of our client population. Sixty five percent in the form of crack, 5% in the form of cocaine powder and 5% in the form of coca paste or Bazooka. 70% of the cocaine using population we work with is in the 20 year old range with 25% below twenty and 5% above.

From these statistics it is clear to us that Crack is a major problem in our area. It has touched every socio-economic group from teenagers who are surviving in school to white collar workers who hold responsible jobs. We suspect and have had individuals state that they have used drugs for a number of years and somehow managed to stay in control - that is until they used crack. We believe that because of the highly addictive nature of crack on the brain's biochemistry that an individual is driven to use more and more of the substance. Simply stated the nerve cells of the brain communicate with one another with the help of chemicals called neurotransmitters. Crack triggers the brain tc release these substances at once. The result is an neurostimulation. Cocaine blocks the return of the neurotransmitters to the nerve cells for reuse. Eventually the brain is squeezed dry and craves stimulation. Addicts who try to recapture the high by smoking more crack aggrevate the neurochemical deficiency causing depression, irritability, paranoia and craving.

As the result of the widespread abuse of crack and other drugs, programs in New York are experiencing long waiting periods before people can receive treatment. In addition because of the craving for crack more and more youngsters and adults are committing crimes and are entering into the juvenile and criminal justice systems causing massive problems. Having worked 20 years in the field of substance abuse I have never seen anything like it.

Since the beginning of the Outreach Project it has been our policy to go to those places where drugs were being sold and let it be known that if anyone wanted help because of their substance abuse we would be willing to help them. We made it clear from the beginning what our role was and that if you want to deal drugs or use drugs we were not about to say anything. In other words no preaching, just help if you wanted it. The result was that as dangerous as the work was our staff was well received, but we made it clear we were not police, but people who were concerned about them and the pain in their lives.

However, because so many people were now coming to our offices for help we found it impossible to continue to do Outreach work. In seeing how widespread drug abuse was and realizing that we could never cover every nook and cranny of the county we decided to develop a Substance Abuse Ministry Training program. We offered four weeks of training to appropriate and concerned community individuals on implementing a strategy for dealing with drug abuse in the community.

The four week program consists of the following (please see attachments). In addition to the initial curriculum all graduates of the program are offered the opportunity to take part in a presentation on a special topic of current interest and these presentations are offered monthly.

We are very excited about this program because over 200 adult volunteers have graduated from the program and have become eyes and ears for Outreach throughout Queens County. Since this program was initiated we have held a Queens wide conference on substance abuse by attended over 350 people. Many of the SAM graduates have also established special programs in their communities and one group started their own hot line and are currently doing Outreach work in the streets.

The end result is that many individuals who are abusing drugs and alcohol are being identified faster and are being referred for help earlier. We now have SAM trainees doing Outreach work in their own communities which they know best. This is allowing Outreach staff to concentrate on helping the more difficult cases. We are creating an army of individuals who are constantly developing programs which highlight the need for all of us to be more aware of the issue of chemical dependency.

It has been our policy not to duplicate services if they are already being offered by other groups in an effective manner. It became apparent to us within the first year of operation of the Outreach Project that we were running into a problem of placing adolescents 16 years or younger into residential treatment. We found that children could only be placed if the parents were willing to pay thousands of dollars a week for a 6 to 10 week program. The people turning to Outreach for help simply don't have thousands of dollars a week to spend on help even though they love their children. We felt that car wash programs were too short, did not have adequate family involvement and give unsatisfactory after care. On the other hand we also felt that a number of youngsters who were marginal substance abusers did not belong in long term 18 to 24 month programs.

We were determined to establish a model short term 9 to 12 month residential program to reach a population of youth who were not being serviced by traditional drug treatment programs. In November of 1984, we opened such a program; Outreach House. This program combines the most effective aspects of the anonymous program model and therapeutic community model to produce a structured environment in which the clients can begin to understand and accept responsibility for their own behavior. This program is highly focused on the family unit and stresses the involvement of every available family member in order to achieve a more comprehensive level of functioning.

Outreach House is the first jointly funded (The Division of Substance Abuse Services and the Division of Alcoholism Services) short term residential program in the New York area. It was our finding that the majority of the youngsters who were coming to us for residential care were duly addicted to drugs and alcohol.

We also have become aware that 85% of the youngsters receiving treatment at Outreach House come from families where alcohol abuse is a major problem. I must admit getting the Division of Alcohol Abuse to talk the Division of Substance Abuse about funding a short term residential program was a long and difficult process, however, reason won out.

Outreach House residents are required to participate in every aspect of treatment provided by the program. The following treatment modalities apply.

Crisis Counseling	As needed
Individual Counseling	Once a week
Group Therapy	2 times per week
Family Chemical Dependency Educational Group	Once a week
Monthly Parent Meeting	Once a week
Multi Family Group	Once a week
Parenting Skills Group	Once a week
Single Parent Group	Once a week
Family Therapy	Once a week
Family In-House Self-Help Meetings	Once a week
Female Group (for female residents)	Once a week
Male Group (for male residents)	Once a week
Resident Alcohol/Substance Seminar	Bi-weekly
Nutrition Seminar	Once a month
Education	Three hours and twenty min. per day
Young Peoples' A.A.	Two times per week
Young Peoples' D.A.	Once a week
Children of Alcoholics	Once a week
Recreational Activities	3 times per week
Hobby Hour	Once a week
Cultural Events	Once per month
Morning Meetings	Daily

All Outreach House staff have backgrounds in Social Work, Counseling, or Psychology. In addition some of the staff members are Certified Alcoholism Counselors. Vocational/Employment Services are provided by a vocational counselor including vocational assessment, career development workshops and when a youngster is in the final stages of re-entry, we then have re-entry counseling with additional placement services provided by our outpatient offices.

Since we have opened our doors for residential treatment in November, 1984, we have had 14 graduates of Outreach House. Of the 14 graduates two of the graduates have gone back to doing drugs - one continues to use alcohol and the other is now back in treatment because of his use of crack. The others are doing excellent and the 12 return everytime another resident graduates.

I would love to go on to really give you an in depth presentation on the issue of crack, Outreach House and Substance Abuse Ministry Training Programs. However, if I may, because of time considerations tell you from where I work that there is a need for a National Strategy not only on drug abuse but also on youth. Our whole educational system needs to be evaluated. Teenagers need more individual attention in dealing with crisis in their lives. We need better trained teachers and counselors who are going to be able to anticipate ways in which youngsters can cope with problems.

What I see happening is the creation of an anti-child movement in this country. It seems that many kids are looked at as indentured servants whose major function in life is going to the store, babysitting and taking out the garbage, I am not surprised that crime, drug use, sexual abuse, and youth exploitation are at an all time high among youth. Communities complain about kids hanging out in school yards and street corners but take no advocacy role to really explore what can be done to help them. Our society seems to have no real commitment to developing programs that work. A clear example of this is illustrated in how we allocate or don't allocate government funds. Since 1980, our country has experienced a major growth in drug abuse. The Federal Government response has been to reduce New York States federal funding for drug/alcohol abuse by 40%.

It is clear that we have to take a hard look at the situation of family life, education, employment and youth problems. We need to prioritize people. We need to see what is working and use various models which can be replicated in other parts of the country. The light of hope is dimming for alot of young people today because, it appears, that the advocates for youth are far and few. Thank you and if you have the time please come and visit us sometime soon.

SESSION I

I. Purpose of SAM Training

The Substance Abuse Ministry workshops are for concerned individuals who want to provide assistance in the communities with regard to solving the problems of chemical dependency. This program is designed to educate and train individuals in the areas of substance abuse prevention and intervention. Basic skills in intervention will be taught, as well as interventive strategies that can be applied to working with individuals, groups, and organizations. It is our hope that after taking this workshop individuals will develop and implement their own community project that will aid in solving the problems of substance abuse.

II. Overview

A. Group Process: Group should be sitting in a circle. Individual group members should introduce themselves and explain reason and purpose for taking the SAM training. Format and topics for workshops should be discussed. Discuss confidentiality.

B. Overview: Utilize materials in training manual.

C. Film: Prepare audience for the film. Discuss the film afterwards.

D. Discuss assignment to be completed by Session IV.

SESSION II

PHARMACOLOGY

I. Definitions

II. Discuss printed material given out on pharmacology

III. Current trends in drug abuse

IV. Drug interactions

V. Drug abuse treatment

a) de-tox
b) drug-free rehabilitation
c) overdose
d) residential

SESSION III

INTERVENTION

The purpose of intervention is to assist "at risk" and substance abusing youth live a drug-free and emotionally healthier life. This can be accomplished by working with individuals, groups, and organizations. The basic tool of intervention with individuals is an empathic relationship. It is through this relationship that the intervener can influence and assist a young person in making choices that will lead them towards leading a healthier and more fulfilling life.

OUTLINE

Identification of individuals who need assistance

A) behavioral changes and signals
B) observation of behavior relating to drug or alcohol abuse
C) knowledge of individual

Relationship

A) non-judgemental attitude
B) listening skills
C) privacy
D) confidentiality
E) empathy caring
F) consistency
G) "rescue fantasy"

Assessment

Try to get a clear picture of all of the individual's problems

A) psychiatric
B) drug and alcohol related problems
C) school
D) family
E) organize problems in regard to priority
F) evaluate support systems

SESSION IV

I. Referrals

- A) community resources
- B) social service agencies
- C) hospitals
- D) queens Outreach
- E) emergency telephone numbers
- F) emergency procedure

II. Discuss assignments

III. Develop community project

- A) ideas
- B) develop steering committee

U.S. HOUSE OF REPRESENTATIVES
SELECT COMMITTEE ON
NARCOTICS ABUSE AND CONTROL

AND

SELECT COMMITTEE ON CHILDREN,
YOUTH, AND FAMILIES

Hearings to Examine the Nature and Extent of Crack use Among Youth and Adolescents

Testimony Presented By:

John F. French, M.A.
Chief, Office of Data Analysis and Epidemiology
Alcohol, Narcotic and Drug Abuse
New Jersey State Department of Health

July 15, 1986

I am grateful for the opportunity to appear before you today.

The use of Crack is becoming a major problem in New Jersey, particularly in the northern urban areas. There are several aspects of this rapidly spreading epidemic to discuss, especially in their relationship to youth. They are:

- marketing processes,
- pharmacologic effects, and
- treatment dynamics.

Marketing Processes

Cocaine HCl, the commonly distributed form of the drug, has been widely available and popular for a decade. It retails for about $80-100 a gram, depending on the sophistication of the user, at purity levels of 30-60 percent.

Crack, on the other hand, is sold in small vials containing about 100 mg., for $10 a vial, at a purity of more than 90 percent in New Jersey.

These differences in price and purity provide a major element in an explanation of the rapid spread of Crack use--more rapid than any other drug epidemic I have seen in my experience.

A kilogram of cocaine HCl brings a final gross income, with each level in the distribution network receiving its share, of about a quarter of a million dollars. The same kilogram, converted to Crack at its high purity, brings a gross of only about $100,000.

These are only rough estimates, but they make the point that the sale of Crack means a monetary loss. In a competitive market, the only explanation for this is an imbalance between supply and demand. It is very clear that cocaine is coming into this country much more rapidly than it is now being used.

In terms of marketing strategy, a good short term response to an excess of supply is price reduction coupled with product enhancement. Crack serves this purpose well. The market is opened to those who could not have afforded the higher priced product. That means that many youth are now able to afford a vial of Crack.

We can anticipate several future developments in this process. First, in the short-term, the over-supply of cocaine will continue, despite efforts to reduce production and interdict the drug. Second, also short-term, prices are very likely to continue to decline, thus increasing incidence and prevalence.

However, we can hope that supply reduction efforts will have a long-term effect of reducing the imbalance between supply and demand. But it will be at that point that an already bad situation could become worse. The reasons for this lie in the pharmacologic processes and dynamics of treatment, and I will discuss these later.

Meanwhile, I should comment that efforts by your committees, governmental agencies, the media, and others to bring the problem of Crack to the public view are an important and necessary part of the effort to combat the problem. However, like all such efforts, they also contribute in their own way to its spread. In effect, they must be partially viewed as part of the marketing process, and hence must be carefully mediated.

Complex marketing processes alone do not fully explain the seriousness of the Crack problem. Let me turn now to pharmacologic effects.

Pharmacologic effects

We already know that cocaine is a powerful self-reinforcer. For the majority of users, who snort cocaine, Crack provides an acceptable alternative means of ingestion. The effects of smoking Crack compared to the effects of snorting cocaine are remarkable. The onset of biological activity of Crack is far more rapid--a matter of only seconds compared to minutes. And the intensity of the action is far greater, although the duration of action is substantially shorter.

Again, from a marketing point of view, this combination makes Crack almost a perfect product enhancement. It's better, it's cheaper, the customer's supply is exhausted more quickly, and finally, the effect is perceived as being far more pleasurable.

We have never seen a drug that seems to produce such a rapid loss of control as Crack.

One of my staff interviewed a sixteen year old girl who uses Crack, and reported that her entire life is focused on this drug, although at that time he doubted that she was being completely honest. What shocked both of us was the fact that the interview had taken place on a Friday, and the girl claimed that she had first used Crack on the previous Monday. Within five days this young girl had completely lost control over her life.

This is the most extreme example we have seen to date, but it has become completely believable to us as we have continued to observe more new users.

In addition, we also believe that a higher proportion of users lose control than do with other drugs. Each drug has its own curve of abuse. Alcohol, for instance, is widely recognized as having a curve in which roughly ten percent of users have severe problems. We do not have a clear picture of the curve for Crack, but our impression is that the proportion of users who will eventually have severe problems is higher than for any drug we have seen as widely used.

Cocaine is recognized as being associated with violence. As a sociologist, I tend to look first for behavioral explanations, but with cocaine, I agree with those who see a pharmacologic action which fosters violent behavior significantly more than that associated with most other drugs.

In the process of gathering information on Crack, we obtained information about events that took place when a "Crack House" was robbed. The descriptions of some users present during the robbery drive several points home.

The first thing the robbers, undoubtedly Crack users themselves, did was to shoot the proprietor to death as they shouted for everyone else to "freeze." While one held a weapon on the almost two dozen users in the house, the others gathered up vials of Crack and money. At least four people continued to smoke Crack while the robbery was in progress. For these people to continue to smoke, to get as much of the drug in their system as they could, while in the midst of such a life threatening situation is nothing short of astounding. And as a final fillip, the robbers took a shopping bag and collected the pipes containing Crack residue from everyone in the house as part of their booty. This is akin to a robber collecting pennies from the customers while robbing a bank.

All of these properties affect treatment dynamics, which I will now address.

Treatment Dynamics

In 1980, less than one out of 25 treatment admissions in New Jersey reported cocaine as their primary drug problem. Now it has reached about one out of six. Over half of all admissions report a primary or secondary problem with the drug. When we consider that the system is geared to provide services to IV heroin users, this increase is surprising.

Although we have not yet seen large numbers of Crack users entering treatment compared to traditional cocaine users or IV heroin users, we are already starting to see the effects of the rapid spread of the drug in the treatment system as the proportion of cocaine admissions who smoke rather than snort increases.

Users and their families generally are more reluctant to admit the problems they have with Crack compared to some other drugs. The process of denial seems to be greater for Crack. It appears to take longer for a Crack user to "hit bottom" than heroin or alcohol abusers. The occasional Crack user might "crash," or experience a period of depression immediately after the effects of the drug have worn off, but the next day or so these feelings are gone; the user again feels normal and believes he does not have a problem.

Virtually all treatment programs in New Jersey report a large volume of calls about Crack, from users and families, but these are not yet followed up with admissions to treatment. The ongoing seduction of the drug overrides their temporary problem recognition. These dynamics explain why we have not yet seen an influx of Crack users in the drug treatment system.

To return for a moment to my previous comments, the combination of marketing processes and pharmacologic effects leads to a potentially dangerous scenario: as the price increases in the long term, chronic users will "hit bottom," and the treatment system will see the greatest demand for services. However, as a result of the increase in price, we can expect many occasional users to stop, thus giving society the impression that the problem has been solved, and that resources for treatment and prevention should be reduced.

Treatment program managers in New Jersey are trying to plan for programs to deal with the expected increased treatment needs of Crack users, but they are concerned about three issues.

First, they are concerned about the difficulty of recruiting Crack users into treatment, compared with the users of other drugs.

Second, they recognize that less expensive outpatient treatment processes will not always be sufficient to overcome the seductive properties of the drug.

Third, and most important, the entire health care system in New Jersey is in the midst of a fight against the most severe health crisis of this century--AIDS. In our State, the drug treatment system is our first line of defense in that fight. With drastically reduced resources, we must attempt to stop the spread of a virus which we believe will kill more than one million people nationally in the next fifteen years.

Drug treatment counselors in New Jersey are burned out. The AIDS virus is killing their clients, people they have grown to know over years of work. Just recently an ex-addict staff member of one program who had been drug free for more than four years, and who had become a productive member of society, died of AIDS.

Very often counselors go home after a day at work and cry in privacy over the loss of clients they have seen make positive changes, yet who are dying. And sometimes they are unable to wait until they get home. Believe me, it is a rough situation.

Now, in the midst of this catastrophe, we must face a new and potentially dangerous Crack epidemic. It is easy to repeat to you the usual cry of State agencies--we need Federal support, in a three pronged effort--increased resources to support supply reduction, prevention and treatment to combat the Crack epidemic.

We ask for your support of currently proposed legislation to increase general revenue appropriations for prevention and treatment. Another mechanism for obtaining resources could be through dedicated excise taxes placed on the three major legal dependence-producing substances--alcohol, nicotine, and caffeine. There should also be Federal pressure to aid State efforts to allow private health insurance reimbursement of substance abuse treatment.

In closing, I present our dilemma to you in a very personal way. My role in the New Jersey State Department of Health is to gather and interpret data to inform policy making. How do I inform policy in a situation of limited resources, in which I am asked to respond to a question that breaks down to something like this: my own four children, along with every other youth and young adult in the country, are at risk for infection from the AIDS virus through heterosexual transmission, and they are also at risk for Crack use through peer pressure--what is my recommendation if given the choice of saying who should die, and by what means? How can I make that decision?

How can our drug treatment system be asked to make the decision to reallocate grossly inadequate drug treatment resources that are now being used to fight a battle that needs every resource the nation can muster?

As a society, we must immediately decide what our priorities truly are, and how much we are willing to spend to save the young people who are our future.

"Drug Abuse Prevention: The Role of the Schools"

Statement by

Malcolm Lawrence
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presented at the

Joint Hearings on the Problem of "Crack" Cocaine

held by the

House Select Committee on Narcotics Abuse and Control

and the

House Select Committee on Children, Youth and Families

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It is an honor for me to appear at these vital hearings on "crack," the newest treacherous drug form. I have dealt with both the supply and demand sides of the drug problem at the local, national and international levels. My remarks today will focus on the role of the schools in drug abuse prevention. I shall be drawing from my experiences as chairman of the board of an American-sponsored international school in Switzerland from 1965 to 1967; as head of the War-On-Narcotics League of Montgomery County, Maryland, from 1969 to 1971; as a special assistant to the U.S. Secretary of State for international narcotics control matters from 1971 to 1977; as a consultant to the U.S. Department of State on Freedom of Information narcotics cases from 1979 to 1985; and from 1974 to the present as Coordinator of the Maryland Coalition of Concerned Parents, a group networking with various other organizations throughout the United States; as well as from my participation in numerous radio and television talk shows.

News stories proliferate about the tragic cocaine-induced deaths of 22 year-old Len Bias, former University of Maryland basketball star, and Don Rogers, 23 year-old defensive back with the Cleveland Browns. Among the questions raised is the very basic one: "Why did Bias and Rogers use cocaine?" The answer is two-fold: they used cocaine BECAUSE THE COCAINE WAS THERE and BECAUSE THEY REALLY DIDN'T KNOW ANY BETTER. Obviously, neither one was attempting suicide.

When the stories of the deaths of Bias and Rogers subside, will our nation forget about the drug problem and go back to sleep until the next superstar expires from cocaine or some other substance? I hope not. Like Bias and Rogers, millions of other American youngsters are taking cocaine and all kinds of other illegal drugs because the drugs are available and are tolerated by our society.

The American people are, quite frankly, growing weary of a problem that has plagued us for two decades. There is a real job to do. We must all face in the same direction and destroy an annual 100 billion dollar industry that threatens the moral fiber and economic base of our society.

A major contributing factor to the tolerance of illicit drugs and narcotics in America is that many of our schools are sending out weak and confusing messages. Since the early 1970s, educators have been brainwashed by permissive pundits and curriculum developers to believe that scare tactics and facts about drugs are counterproductive and that the solution to the drug abuse problem for students is to use a values clarification approach, apply compassion, give counseling, set up hot lines, and at all costs avoid using the word "don't" when discussing drugs. The fashionable approach in drug education has been to let the children examine all aspects of their feelings, attitudes, values and societal pressures and then make their own decisions about whether to use drugs.

In point of fact, our schools never really did use scare tactics or give adequate factual information about the serious effects of drugs on the body, the brain and the genes. Those who say that scare tactics and facts have failed are usually the ones who make the ridiculous argument that law enforcement has failed, the implication being that we have to give up law enforcement and try something else. As any sensible person in the drug battle knows, we need all the help we can get.

In my 17 years of experience in dealing with the drug problem, I have read much drug curriculum and talked with many parents. I have yet to come across any good, solid, effective education. I have, however, become acquainted with some poor curriculum. Let me cite some examples.

Heading the list of wrong-headed education is the values clarification approach exemplified by the widely used but highly controversial kindergarten through 12th grade curriculum called, "Here's Looking at You, Two." This misguided package dwells on stress, fear, anxiety and unpleasant situations, but does not teach about the real dangers of illicit drugs or that taking drugs is wrong.

Another curriculum that misses the mark is called "Ombudsman," which was developed with funds from the National Institute on Drug Abuse. "Ombudsman" has very little information about drugs, but exposes 5th through 10th graders to such things as role playing, encounter activities, feelings charades, warm fuzzies, love lists, self portraits, personal questionnaires, the trust fall, the human knot, who shall survive exercises, gravestone statements and death notices.

Even children in grades 1 through 6 have to suffer through a values clarification course called, "The Me-Me Drug Prevention Education Program," developed 11 years ago with U.S. Office of Education Title III funds. Little 6 and 7 year-olds learn all about their full potential, self concepts, decision making, peer pressure, Mr. Yuk, and developing positive feelings toward their teachers. Unfortunately, "Me-Me" and "Ombudsman" are still being promoted by the National Diffusion Network of the U.S. Department of Education.

There are elementary level drug courses that classify all kinds of substances into the harmful basket category -- coffee, tea, soft drinks, aspirin, tobacco, cough syrup, beer, marihuana, heroin, cocaine, pills of all sorts, etc. -- conveying the notion that the differences are minor. To a small child, if something is bad, it is bad. This type of education presents a real problem for the 7 year-old who may tend to equate drinking a cup of coffee with shooting heroin.

Some schools give 2nd and 3rd graders an assignment to explore the family medicine cabinet and take inventory of what they find. It is amazing how curriculum developers try to encourage curiosity in children well beyond their maturity levels. It is even more amazing that school boards approve such curriculum. Showing a small child where mom's sleeping pills are can be the same as handing him a loaded gun.

About the most asinine approach I have come across is from the 7th grade drug curriculum in my own community, Montgomery County, Maryland, which opens as follows:

> "Currently, community concern regarding drug misuse is centered on today's youth. They are growing up in a world full of problems for which they see no immediate solutions. Young people in adolescence undergo bodily changes with related emotional pressures. Superimposed on this is peer pressure, accompanied by the 'fad syndrome.' It is not surprising, therefore, that many young people are seeking an escape through drug experimentation."

This message implies that earlier generations did not experience bodily changes, emotional pressures, fads and peer influences and were able to solve all of their problems. Therefore, those people didn't need drugs. Such rationale is not only stupid, but is an open invitation for 12 year-olds to enter the drug culture.

It is no small wonder that drug abuse education in our schools is getting such a bum rap. It is also no small wonder that there are 20 million persons admitting to using cocaine, five million regular cocaine users and up to one million cocaine addicts, as well as half a million heroin addicts and countless millions of abusers of marihuana, PCP, and other illicit drugs. Will crack get as strong a hold on our youth as marihuana has?

My observations may be limited, but I have reached the conclusion that our wishy-washy approach on the demand side of the drug problem has been a major contributing element to addiction and death among our youth. In a word, our schools are not tough enough. The solution is not more values clarification and situation ethics, but factual instruction backed up by a no-nonsense school policy.

I have been asked to comment on the federal government's responsibility to encourage greater school participation in anti-drug efforts and how this responsibility should be met. I have a recommendation.

We need to know much more about what is going on in the schools. As we begin the third decade of drug crisis in America, I believe it is high time we found out precisely what our children are being taught throughout the country and how school administrators are dealing with the drug problem. Has the values clarification approach taken over completely? Are there some effective programs and policies deserving of adoption and application by schools nationwide?

I urge the House Select Committee on Narcotics Abuse and Control to undertake a study to analyze how the public schools throughout America are dealing with the drug problem. There are some 15,500 school districts, and it would, of course, be too costly and time-consuming to find out what each and every one is doing. However, I believe the Select Committee would be providing a highly valuable service by surveying the 50 state boards of education and taking a sampling of some 200-300 local school districts -- that is, four to six districts in each state -- to obtain a representative cross-section of the following two aspects of drug abuse prevention:

1) the thrust of the drug control policies in the schools and
2) the nature and contents of the drug abuse curriculum.

Such a report should be completed by the spring of 1987 so that the Select Committee could provide valuable findings and recommendations for the 1987-88 school year.

I am well aware that the National Institute on Drug Abuse is in the process of preparing a study on exemplary anti-drug programs in the schools, but I am also aware that NIDA has been less than effective in prevention measures and policies. NIDA and its predecessors have traditionally had a soft-line, mental health approach to the drug problem. Since the late 1960s, these prevention agencies have been followers rather than leaders. Based on my years of experience of working with drug control agencies at the federal level, I do not think a survey of drug education programs should be left to NIDA, the Department of Education or any other executive body. I believe the Congress should conduct an independent survey and make a set of recommendations as to how our public schools might best help in curtailing drug abuse in our nation.

I have also been asked to provide comments today on what needs to be done to strengthen school-based drug abuse prevention efforts. Drug abuse prevention is, of course, a blend of education and enforcement. On the enforcement end, the controls include international and bilateral agreements negotiated by the U.S. Department of State to curtail the flow of drugs and narcotics into our country, border inspections by the Customs Service, interstate control efforts by the agencies of the Justice Department, and the enforcement facilities of the state and local police. This down-the-line control is carried out by official organizations which we maintain through tax dollars to keep illicit substances from reaching the end-users who constitute the effective demand. Why?

We do it because it has been determined that the abuse of certain drugs is dangerous, insidious, and a menace to society and that steps must be taken to restrict the traffic in the interest of the public welfare. In other words, as a nation, through those agencies charged with the maintenance of law and order, we are saying "The abuse of illicit drugs is harmful and, therefore, wrong."

It seems clear to me that the reasons for the enforcement measures in the area of drug abuse should form the basis of our educational approach. Indeed, the message to be emphasized in the home, in the schools and by the media should be the straightforward extension of the findings of the medical and chemical experts as well as the justifications for the laws. --

A massive supply of drugs and narcotics has slipped into our midst within the past two decades, but this does not mean we should in any way foster the notion promoted in our schools that each person be permitted to make an independent analysis and decide whether or not illegal drugs are the thing for him. It cannot be viewed as a civil right and a privilege for any individual to dabble in such substances and in the process drag others with him down the road to addiction and crime. It is nothing short of ridiculous to devote so many of our resources to cutting off the supply of drugs and at the same time carry on with a soft, compassionate approach at the demand end.

We are not trying to curtail the supply simply to give enforcement officials something to do. There is a much better reason, and that is to keep the drugs and narcotics from the end-users. If the abusers and the prospective abusers do not understand this, then perhaps the message should be put across much more emphatically than it has in the past. We should stop teaching the reasons why children take drugs and instead teach them the very basic and perfectly clear reason children should not take drugs. The message should go to young and old alike; the young do not have a monopoly on self-abuse.

Drug abuse education can only be effective if it is done correctly, if it tells the practical truth. There is no need for a pro-and-con debate. Drug abuse is bad. It can destroy the mind and kill the body. In a word, it is stupid. This is a very simple truth, a sad one reported daily in the newspapers. Hence, we should moralize about the subject. We should say it is wrong to abuse drugs and to abuse yourself. We should say, "Don't."

Let's face it. A large percentage of our youth has been suckered into a drug-oriented cult, whether on a street corner, in a school yard or at a rock festival. At the same time, many otherwise clear-thinking adults have been duped into believing that a vast range of social and psychological pressures has forced children to rely on a crutch to soothe their natural and normal growing pains, a crutch which is preventing a portion of our youth from maturing, facing reality and earning a decent place in society.

To correct the situation, we should cease agonizing over the problem and adopt a constructive policy in every community. This can be done by the implementation of some very simple preventive measures to complement the efforts of the law enforcement authorities.

Working from the premise that the elimination of the criminal sources of drugs and narcotics is essentially a policing problem, the rest of the community can make a major contribution on the demand front by convincing the older children of today that they should turn their backs on illegal drugs and brand them with a stigma for their younger brothers and sisters. If by pulling together we can break the upward trend for the current crop of students, the problem could be solved. I firmly believe that if the students themselves through a coordinated effort would decide to inform on or ostracize those individuals who are scorning the law by using or passing out illicit drugs on school property, then the hard-core group of drug enthusiasts would quickly be convinced to change their ways and the drug abuse problem in any given school area could be cleared up almost overnight. However, since the students display little evidence of taking on the job, the changes must be brought about by other means.

Obviously the family unit is where the most good can and should be done. However, there are outside forces working on the children which can very easily tear down the principles of a well-disciplined home. The offspring of permissive or indifferent parents can go a long way toward inducing the correctly-trained child to take a wrong step rather than run the risk of being rejected by his peers. To do the "in" thing can be a powerfully motivating drive. The friendly sharing of drugs is how it all starts; it puts the temptation there, leads to the first step and produces the "highs" that lure the child further into experimentation until he reaches the point of willingly paying for future supplies.

If the students and the family units cannot do the job of combatting drugs, the community must somehow be pulled together, and this can best be done through the local school system.

Since children spend almost half of their waking hours, five days a week, involved in school activities away from home, the schools constitute the most important focal point for the youth of the community and should spearhead the drive against drug abuse. The public schools are a multi-billion dollar infrastructure working for parents and taxpayers. They are well placed to do the job. The selection of the school system does not in any way imply that the schools are the source of the problem, but is merely a plan to unite the community as a whole toward a solution to the drug problem. The opportunity to assume leadership should be readily acceptable to any correct-thinking school board or administration; to refuse this responsibility would be an error of omission. The local board should be pressured to move toward a position of leadership. The parent-teachers associations and the network of business, professional, social and neighborhood civic organizations should rally to the cause and support a consolidated campaign, rather than conduct a splintered program.

Dealing with the drug problem in the schools calls for much more than "busting" students and throwing them out of the system. Rather, every board of education should formulate a Policy Statement on Drug Abuse which for all practical purposes should apply to the middle school through senior high levels. The Policy Statement should be a community education document. Thus, sufficient copies should be printed and disseminated to parents, students, religious leaders, civic clubs, and other interested groups.

The Policy Statement should condemn the abuse and distribution of drugs and narcotics as defined under the law and implement a constructive action program to combat the problem during school hours and on school property. Specifically, it should do the following:

1. Outline the scope and dangers of drug abuse;

2. Define the penalties under county, state and federal laws for the abuse and distribution of drugs and narcotics, including the penal procedures for juvenile offenders;

3. Identify the principal types of drugs and narcotics as well as the symptoms to look for in persons under or suspected of being under their influence;

4. Spell out the administrative measures to ~~the~~ be implemented by school authorities on an area-wide scale to curtail the illegal use and transfer of drugs and narcotics on school property, including school vehicles;

5. Indicate the precise procedures to be followed by school personnel when drugs and narcotics are found on school property and when students are determined to be or suspected of being under their influence.

In developing the administrative measures for inclusion under item 4, school officials should, of course, make a careful study of the conditions contributing to the abuse of drugs by students. They should take into consideration the adverse influences of such things as:

- Inadequate security against unauthorized persons on school grounds,
- Off-campus escapades by students during lunch and other free periods,
- Roll-taking procedures,
- Carelessly administered smoking regulations,
- Presence of publications and student organizations glorifying and advocating the use of illicit drugs, and
- Harboring of drug abusers by school personnel serving as confidants.

Should these or any other factors be contributing to the drug abuse problem, counter-acting regulations should be incorporated as component sections in the Policy Statement and rigorously enforced by the school authorities.

Whatever else might be included in the Statement, there must be a provision calling for absolute and complete cooperation on the part of school administrators with the local police department to eliminate the sources of supply in the area and prevent the casual experimenters from moving on to other drugs and possible addiction. Indeed, the withholding of information concerning the illegal sale and possession of drugs and narcotics is in itself an offense under the law and can be prosecuted.

A logical way of maintaining drug abuse control in the district would be to designate a senior official at each school -- ideally the principal or assistant principal -- to serve as the central reporting point for all instances of use, sale or transfer of illicit drugs and narcotics on school property. If the system works, such officials would be able to gauge the extent of the problem in their schools and through simultaneous notification of the police and parents could quickly bring about corrective action. While a student offender's name would be turned over to the police, he would not necessarily be taken into custody or "booked." Rather, the police could schedule an appointment for the parents to bring the child in for a discussion.

If it should be the student's initial experience with drugs, it would be far better for him to receive guidance from a police official in the presence of the parents rather than have his problem covered up and withheld from parents by a school staff person under a state confidentiality law. Differences in the qualifications and attitudes of teachers, counselors, nurses and other school employees tend to yield variations in the guidance offered. Moreover, it is most unwise to cover up a situation which should be reported to the parents if to no one else. Should the child be a repeated abuser, there is all the more reason for his practice to be reported to prevent him from continuing on a path to self-destruction.

In any event, consultation with police officials would impress upon the child the harmful effects of drugs as well as the seriousness of criminal arrests and serve as an excellent deterrent against further experimentation with trouble via the drug route. In short, he will have been adequately and officially informed and warned. If he abuses or in any way gets involved with drugs again, he does so in defiance of the law. If and when apprehended, he should be appropriately disciplined. Obviously should the offender be addicted to cocaine, heroin or some other narcotic, he should be removed from the school system and committed to a rehabilitation center.

I wish to re-emphasize that the Policy Statement on Drug Abuse should go to all school personnel, parents and students so that everyone in the system is aware of the rules.

In addition to its regulatory function, the school's Policy Statement should provide the basic thrust for the drug abuse curriculum in the classroom. Instruction should be factual, uniform and uncomplicated. It should be included in routine fashion with the treatment of ~~other~~ health hazards such as alcohol and tobacco and handled in a matter-of-fact way as a component part of the health education instruction. Students should be tested on their knowledge of the subject matter to ensure proper understanding. There should be no glamorization of the topic of drug abuse, ~~so~~ no soppy mysticism and no soul-searching seminars on the deep-rooted causes and significance of the drug phenomenon in our society. There should be an absolute minimum of films, and those shown should be selected with the greatest of wisdom.

I am firmly convinced that if drug abuse education is overdone, it will not only bore the students, but will expand the base of the problem. Student exposure to all aspects of drug abuse on a kindergarten through 12th grade basis would not represent a panacea; it would instead only increase curiosity and lead to greater experimentation with drugs and narcotics. School authorities would do well to keep the instruction within the limits of an informative message and not treat drug abuse as a behavioral science by putting it on a psychological altar. In my view, the 6th grade would be the appropriate starting level for most school areas.

Let me say in closing that the adoption of a constructive policy by the school system of each community in our nation would have a profound influence on the local population in the following ways:

- The subject of drug abuse would be placed in proper perspective, and the current cloud of frustration that tends to mark the reliance on drugs as a predestined curse on the young would drift away.

- The healthy, hardy, fun-loving "in" groups of abusers would be ostracized by their peers and would no longer be considered either fashionable or tolerable.

- The youth of the community would become far too wise to serve as legal guinea pigs for the older libertines and libertarians who dedicate themselves to the worship and use of marihuana, LSD, PCP, cocaine, heroin and other illegal substances.

- The cop-out mentality would disappear because the children would realize that whatever they might want to do, they could do it better without drugs.

- Parents would begin to look to their own life-styles and appraise themselves as examples to their children.

- Gradually the community would learn that the supply of drugs, whether legal or illegal, does not necessarily create its own demand.

When these things happen, youngsters will no longer use drugs BECAUSE THEY ARE THERE, BECAUSE THEY WILL KNOW BETTER.

Thank you very much.

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SUMMARY

MALCOLM LAWRENCE, Former Special Assistant for International Narcotics Control Matters, U.S. Department of State, Presently Coordinator of the Marylend Coalition of Concerned Parents

People use drugs because drugs are available, and because they don't know better. Schools must be deal with the demand side of the problem, but presently they are not tough enough. Schools are sending mixed messages about drugs, because of an old myth that using scare tactics and teaching facts about drugs are counter productive.

Lawrence recommends a national assessment of 1) drug control policies in schools, and 2) drug abuse curriculum. (This should be conducted by the Select Committee on Narcotics, not an executive agency.)

Many drug education approaches are not effective because they fail to teach kids the facts about what drugs are and why they're dangerous.

The U.S. pours money into drug enforcement which makes the societal statement that drugs are wrong and dangerous, and therefore must be stopped. We must convey that same message to children in school. Drugs are not a matter of choice and civil rights, they are wrong.

Change must be made in the community through the schools. Every school should write out a Policy Statement regarding drugs. That statement should be sent to every parent, student, and school personnel. When a child is caught, the police and parents should be informed. A child should be warned by both the police and the parents that the next time caught, there will be a punitive response. Drug education should begin in the 6th grade, and must not be overdone.

Americans for Substance Abuse Prevention,
Washington, DC, July 30, 1986.

Hon. Charles B. Rangel,
Chairman, Select Committee on Narcotics Abuse and Control, U.S. House of Representatives, House Office Building, Annex II, Washington, DC.

Dear Chairman Rangel: The Americans for Substance Abuse Prevention, and Treatment (ASAPT) thank you for holding hearings on the "crack" cocaine epidemic. You are to be commended for your strong commitment to rectifying this devastating problem and for your leadership role in focusing public attention on this issue.

Our organization represents 20,000 parents, nurses, physicians, and other individuals deeply concerned about the problem of drug abuse in this country. ASAPT believes that only with a comprehensive national policy to address the problem of drug abuse, can we hope to resolve this national crisis.

Again, the Americans for Substance Abuse Prevention, and Treatment applaud you for conducting these important hearings and look forward to assisting you in any way we can. Finally, we would ask that our remarks be included in your hearing record.

Sincerely,

Harley M. Dirks, *Treasurer.*

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